MAUDSLEY MONOGRAPHS

4

ATTEMPTED SUICIDE

ITS SOCIAL SIGNIFICANCE AND EFFECTS

by

E. STENGEL, M.D., M.R.C.P.

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This book presents a new approach to the problem of attempted suicide which has hitherto been regarded as nothing but an abortive form of suicide. Attempted suicide is here for the first time studied as a meaningful and momentous event in the person's life with special consideration of its effects on the human environment. Five groups of persons who have made suicidal attempts have been carefully studied and the fate of the members of two groups has been followed-up over considerable periods.

The study of the social effects of attempted suicide, in particular on human relations, opens up a new approach to the understanding of suicidal acts. Fuller knowledge of the social psychology of attempted suicide may lead to a reduction of the suicidal rate.

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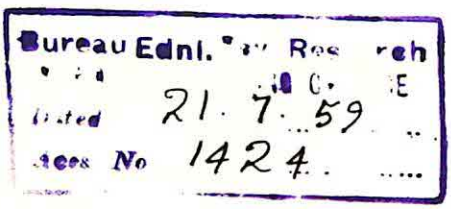

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MAUDSLEY MONOGRAPHS

HENRY MAUDSLEY, from whom this series of monographs takes its name, was the founder of the Maudsley Hospital and the most prominent English psychiatrist of his generation. The Maudsley Hospital is now united with Bethlem Royal Hospital, and its medical school, renamed the Institute of Psychiatry, has become the part of the British Postgraduate Medical Federation entrusted by the University of London with the duty to advance psychiatry by teaching and research.

The monograph series will report work carried out in the Institute and in the associated Joint Hospital. Some of the monographs will be directly concerned with clinical problems ; others, less obviously relevant, will be in scientific fields that are cultivated at the Institute because they provide knowledge and methods essential for the furtherance of psychiatry. In addition, therefore, to accounts of clinical investigations, there will be psychological, social, physiological, biochemical and anatomical studies. The investigations will be of a length and nature which makes publication as a monograph more appropriate than appearance as an article in a scientific journal.

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E. S.
N. G. C.

CONTENTS

A QUARTER OF A CENTURY AGO, on the occasion of a symposium on suicide, attention was drawn to 'the curious fact that such a humane field of research on a contemporary problem should have been so neglected as to make it impossible to find a comprehensive book on the subject written in this country for many years past' (1931). This is as true to-day as then, although much research has been carried out since. A formidable book on suicide appeared some years ago (1951), the long overdue translation into English of Durckheim's famous monograph (1897) in which suicide was examined from the sociological point of view. None of the other numerous publications dealing with this subject aimed at being comprehensive. It is doubtful whether to-day any one author could write a book on suicide which would do justice to the numerous aspects of the problem. The writers of this monograph wish to disclaim any such ambition. They propose to report on their researches into certain aspects of attempted suicide which have hitherto received little or no attention.

CHAPTER 1

THE STATE OF RESEARCH INTO SUICIDE

THE FOLLOWING are the most significant approaches along which the problems of suicide have been studied with the help of scientific methods.

The Sociological Approach. The most important work in this field is still Durckheim's monograph, which presents the sociological views at their purest. Durckheim's pupil Halbwachs (1930) advocated the combination of sociological with psychological and clinical approaches, and nowadays no one would maintain that sociology alone can provide the answers to the problem. Nevertheless, the etiological importance of social and cultural factors is well established, and these have been thoroughly studied in many countries.

Ecological investigations have confirmed the significance of the findings made by Durckheim and his predecessors. Cavan (1928) related the suicide rates in urban districts of Chicago to the degree of social disorganization in those areas. Sainsbury (1955) carried out a similar study of the statistical correlations between the suicide rates of the 28 London boroughs and the indices of their social characteristics. He found that measures of social isolation and mobility correlated highly and significantly with the suicide rates. The important rôle of social isolation was confirmed by him in a survey of a large series of cases of suicide which had come before one of the Coroners' Courts in London. 27% of the total had lived alone, whereas among the general population of the area concerned only 7% had been thus classified.

Cavan and Sainsbury were concerned with urban populations. Gruhle (1940) studied the 'geography' of suicide in Germany and related differences in the suicide rate in certain parts of the country to social and cultural variables. These and other recent studies have consolidated much of the knowledge established by sociologists who pioneered in this field and have shown how it can be applied to limited geographical areas. Cavan's and Sainsbury's work demonstrated the main function of ecological investigations in social medicine: to reveal clearly defined geographical units where unhealthy conditions prevail and to indicate the nature of the remedies.

The anthropological approach can be mentioned here in passing only. Much has been written about the incidence and the patterns of suicide in various cultural settings and in different periods of civilization, most of it anecdotal and contradictory. However, it seems established that suicide, contrary to the belief of some nineteenth-century

sociologists, is not absent in primitive civilizations. It is generally assumed that it has become more frequent with the increasing complexity of modern urban life, but Zilboorg (1936), regarding this as an error based on misleading statistical data, maintained that modern man is deficient in suicidal impulses compared with his primitive ancestors.

The psychiatric approach has followed conventional lines ever since medical men took over the care of the mentally sick. Psychiatrists have naturally concerned themselves with the incidence of suicide in various mental disorders and with its prediction and prevention. Differences between findings have been largely due to differences between the samples under investigation and the diagnostic classifications employed by the various authors, and also to the uncertainties inherent in psychiatric diagnosis. The latter obviously becomes much more hazardous if carried out in retrospect and based on insufficient data. Nevertheless, there is general agreement that only a minority of those who commit suicide were suffering from a major mental disorder, the proportion of these hardly ever exceeding one-third of the total. The problem of the mental state in which suicidal acts are carried out, irrespective of the presence of a mental illness, has long been controversial. Ever since Esquirol many physicians have held the opinion that the act of suicide alone is sufficient evidence of mental disorder. Henderson (1935) reaffirmed this view, and more recently Lindemann (1950) proposed to define suicide as a disease demanding epidemiological analysis. He coined the term ' hypereridism ' for ' morbid states of hostile tension leading to suicide '. Weiss (1954) used an epidemiological approach in his analysis of suicides in New Haven, Conn., concerning himself especially with the correlation between socio-economic status and suicide rates. The controversy as to whether or not suicide is compatible with mental normality seems to be one of semantics rather than of substance, and it is likely to remain inconclusive as long as there is no agreement about the definition of normal and abnormal mental states.

The preoccupation of psychiatrists with the problem of suicidal risk has inspired many attempts to establish criteria of suicidal danger. Clinical experience has provided useful pointers, but the prediction of suicide is still as uncertain as that of other patterns of human behaviour, cf. the studies of Wall (1944), Farrar (1951) and Oliver (1951).

The Incidence of Suicide in the Mental Hospital Population. Psychiatrists *qua* clinicians cannot influence the incidence of suicide in general, because most of those who kill themselves are not their patients; but it may be asked whether psychiatrists have reduced the incidence of suicide among their patients, i.e. among the mental hospital population. All suicides among the in-patients of mental

hospitals in England and Wales are reported to the Board of Control (Ministry of Health). Advances in treatment, and particularly the introduction of physical methods of treatment, would, one might suppose, have reduced the incidence of suicide among this population, an expectation apparently even more justifiable as the most frequent and symptomatically most effective method of physical treatment, i.e. electroconvulsive therapy, is used in depressions with suicidal risks more than in any other condition. Surprisingly, the data do not bear out this expectation. The suicide rates per 100,000 patients resident for the years 1920 to 1947 were about three to five times those among the general population. As among the latter, suicide was more frequent in males than in females. There was no decline after the introduction of the so-called shock treatments during the

TABLE 1

Suicide Rates among the Mental Hospital Population of England and Wales

Year	Number of Patients Resident	Deaths by Suicide	
		Number	Rates per 100,000
1920 . .	98,192	48	48·9
1921 . .	101,898	45	44·2
1922 . .	104,224	53	50·9
— . .	—	—	—
— . .	—	—	—
1945 . .	132,662	65	49·0
1946 . .	133,596	76	56·9
1947 . .	134,025	65	48·5

nineteen-thirties. Table 1 shows the absence of significant change, which is even more remarkable, as the average number resident had increased notably in the interim. However, these findings are ambiguous, as the character of the mental hospital population has changed since the Mental Treatment Act (1930) took effect, with an increase in voluntary admissions and in the proportions suffering from neuroses and reactive depression. Apart from these changes, the older age-groups have recently been more heavily represented in the mental hospitals than twenty or thirty years ago. Detailed analysis of the populations compared would be necessary to understand the significance of the apparently unchanged suicide rates.

There is, however, no indication that the total incidence of suicide among the mental hospital population has changed. The failure so far of psychiatrists to reduce the suicide rates among their patients, demonstrates how difficult this must be to achieve among the general

population. The figures quoted may give rise to various comments; they may appear surprisingly low, in view of the generally accepted high suicidal risk among the mentally ill, and the fact that the vast majority of mental hospital patients in this country are not so strictly supervised as to make suicide impossible. A suicide rate of 50 in a mental hospital population implies one suicide a year in a 2,000-bed hospital. The apparent constancy of incidence in a mental hospital population, in spite of changes in therapy, was also observed by Levy and Southcombe (1953) who analysed the suicides in the Eastern State Hospital, Washington.

The psychopathology of suicide has been given new impetus by psychoanalysis. The well-known inverse relationship between crimes of violence and suicide appeared in a new light when aggressive acts against the self were interpreted as directed against introjected internal objects, and close study of suicidal acts has resulted in a fuller understanding of self-damaging tendencies in general. Karl Menninger (1938) has demonstrated the ways in which such tendencies are constantly at work in all types of mental disorder and personality. A great number of psychoanalytic contributions have followed similar lines. Suicide has also been viewed as a total retreat from the vicissitudes of life (Nolan Lewis, 1933, Moll, 1956). Freud and other psychoanalysts interpreted suicidal tendencies as the manifestations of a fundamental instinct of aggression or 'death instinct', but adherence to that theory is not essential to the psychoanalytic understanding of suicidal acts. Some refused to attribute suicidal tendencies to a primary instinct of aggression. Bromberg and Schilder (1933) saw in them manifestations of an intensified striving towards life and love. Zilboorg (1937) advanced the opinion that the suicidal drive appeared to be endowed with such an elemental force because it sprang from the most vital drive man possessed, the instinct of self-preservation which underlay the assertion of immortality. Masserman (1947) has expressed similar views. For the understanding of suicidal acts it became essential to explore the individual's relations to his human environment, present and past. Deficiencies in the individual's relationship to the natural love objects were found to be important. Psychoanalysts advanced the theory that early loss of love objects, especially of parents, played an important part in the origin of depressive states. Similar deprivations were regarded as responsible for the inability to form satisfactory relationships, with resulting social isolation, which provided the soil for suicidal tendencies. A history of a broken home was found to be extremely frequent in persons who committed or attempted suicide. (Zilboorg, 1936, Palmer, 1941, Reitmann, 1942, Andics, 1947, Batchelor and Napier, 1954, *et al.*). Studies such as these have aimed at discovering the factors which predisposed individuals to suicidal acts, and the

results accorded with those of sociological studies from which social isolation emerged as one of the chief etiological factors in the origin of suicide. However, these observations are inconclusive because similar circumstances have been regarded as responsible for other psychiatric conditions, and also because there is no agreement among the writers as to what a 'broken home' implies.

Other studies have been concerned with a variety of contributing factors, such as age, alcohol, climatic and seasonal factors, motives, methods, etc. (Stengel, 1950).

Prediction and Prevention of Suicidal Acts. This brief survey of the main trends in suicide research will convey an idea of the volume and variety of work in this field. The body of knowledge which has accrued is considerable, but its usefulness for prediction and prevention of suicidal acts has still to be proved, and there is no evidence that it has had any influence on the suicide rates. This is disappointing, considering the efforts spent in this field over almost a century.

The bulk of suicide research, including psychiatric studies, has been statistical. Even in 1881 Morselli could remark: 'Suicide is one of the human acts on which statistical workers have dwelled with special predilection.' A. Lewis (1955) has pointed out the main defects of statistical studies of suicide, i.e. difficulties in ascertaining social, medical and psychological data, and the lack of a coherent sociological theory and method. Yet the statistical method has continued to remain the stand-by of the majority of clinical workers, apart from psychoanalysts. Though none would deny its importance it must be recognized that statistical data, however interesting, cannot compensate for ignorance of important aspects of the problem which have so far received comparatively little attention, nor is there yet evidence that psychopathological studies have helped to reduce the suicide rate. Psychopathology has so far been more illuminating with regard to suicidal tendencies as a facet of human behaviour than in explaining why suicidal acts occur in certain individuals. The methods of clinical psychiatry have not materially changed since the first studies.

The apparent failure of research to prevent a gradual increase in suicide rates must not be taken as an indication that it has not been relevant to prediction and prevention. Obviously, the social and psychological remedies suggested, i.e. measures of socialization and psychiatric treatment, have not been applied systematically. Nevertheless, it cannot be denied that research into suicide has been stagnant for some time, and much has been stereotyped and repetitive. It also has an inherent weakness in that most instances come to the knowledge of the investigator only after the act, i.e. after the individual's death. The factors which led to it have to be deduced, often from inadequate and ambiguous data, and the resulting reconstructions are sketchy and often of doubtful value. The investigator

meets with resistance if he tries to lift the veil that covers the tragedies. The large majority of these psychiatric post-mortem investigations are as frustrating as would be those of persons who died from physical illness and whose bodies are not available for dissection.

CHAPTER 2

RESEARCH INTO ATTEMPTED SUICIDE

THE PREOCCUPATION with those who have committed suicide inevitably limits the scope of research. This is true of the sociological and anthropological, and also of the majority of the psychiatric studies. It is, therefore, surprising how reluctantly and half-heartedly psychiatrists and others have interested themselves in attempted suicide, research into which has been regarded as second best and unrewarding. The survivor of a suicidal attempt is regarded by the public as having either bungled his suicide or not being sincere in his suicidal intention. He is looked upon with sympathy mixed with slight contempt, as unsuccessful in an heroic undertaking. It is taken for granted that the sole aim of the genuine attempt is self-destruction, and therefore the dead are successful and the survivors unsuccessful. This attitude must have been responsible for the fact that until recently research into attempted suicide has been comparatively neglected. It may also explain why attempted suicide, where it has been studied, has been investigated along the same lines as suicide, and not as a behaviour pattern presenting different problems from suicide. As with suicide, research into attempted suicide has been mainly retrospective. A brief survey bears this out.

Sociologists mention attempted suicide only in passing. The numbers at their disposal are usually smaller than those of suicide. *Anthropologists* seem not to have given the problem of the 'unsuccessful' suicidal attempt special attention. *Psychiatrists* have naturally always been greatly interested in attempted suicide and a voluminous literature exists, but until recently these studies invariably followed the same lines as those on suicide.

Ever since Gaupp's (1905) and Stelzner's (1906) publications, the following questions have repeatedly been posed: the occurrence of mental illness and abnormal personalities, motives, underlying social and emotional situations, the rôle of alcohol, age distribution, the comparative representation of the sexes, etc. The only question regularly discussed in connection with suicidal attempts, though rarely in connection with suicide, was the seriousness of the intent. Hendin (1950, 1951) has given this aspect due attention.

Subsequent Suicide. Only in recent years have there been attempts to investigate a problem so obvious that its neglect is surprising: the fate of those who survived suicidal attempts, and the number that finally killed themselves. Dahlgren (1945) was the first to carry

out a systematic follow-up investigation of patients who had attempted suicide. He quoted Stelzner (1906) as having taken an interest in the sequelae of suicidal attempts, but that she was concerned mainly with a specific issue : the classification and prognosis of the psychoses which had led to the attempts in 200 cases. Dahlgren analysed statistically an unselected sample of attempted suicides, i.e. 237 patients treated in the medical and psychiatric hospitals in Malmö. He found, as had others, that suicidal acts by men resulted in death more frequently than those by women, that suicide was more common in higher age-groups than attempted suicide, that there were relatively more divorced persons among attempted suicides than in the general population, that men attempting suicide employed more active methods than women. In Dahlgren's material two-thirds of all suicidal acts committed by men, but only one-third of those committed by women, ended fatally. He also found that 50% of the suicidal acts carried out by men above 50 years of age ended fatally, but only 40% in younger men. However, in his series the older age-groups appeared to be under-represented. Dahlgren's statistical conclusions can be accepted only if one is satisfied, as he seems to be, that the figures for attempted suicide available are about as reliable as those for suicide. During 1933–1942 the number of persons admitted, after a suicidal attempt, to medical and psychiatric hospitals in Malmö was 237. Admissions after an attempt at suicide to surgical wards were not included. The number of suicides during the same period was 290, i.e. the number of attempted suicides per year was even smaller than that of suicides. Dahlgren believed that in Malmö the proportion of suicidal attempts not sent to hospital and thus escaping detection was small, and in his statistical investigations he treated it as insignificant.

Among Dahlgren's instances of attempted suicide, about one-third were suffering from a psychosis. There was only one epileptic. Almost half of the male patients were inebriates ; 10% of these committed suicide later, i.e. about the same proportion as in the material as a whole. In 6% of the whole group there had been a suicide in the family.

The follow-up methods employed by Dahlgren after intervals ranging from 0 to 12 years, in most cases from 2 to 7 years, were as follows. 79 of the 230 persons were personally re-examined, 15 could not be traced, and for the remainder the information was obtained by questionnaires. Death by suicide was established for 14 (9 men and 5 women). All had killed themselves within 4 years after the suicidal attempt for which they had been included in the series. Death by suicide was about as frequent in patients suffering from ' psychosis ', ' psychopathia ' and ' neurosis ', whereas none of the 36 persons for whom no psychiatric diagnosis had been made had committed suicide. About two-thirds of the patients were at the time of the follow-up

found to be 'socially healthy'. About 8% of the men and 40% of the women were either in a mental hospital or were mental invalids at home.

Dahlgren grouped suicide and attempted suicide together under the heading of suicidal acts. Whether the assumed size of this composite group bears any relation to reality depends on the reliability of the figures representing its components.

Dahlgren's work contains much valuable information and he appears to be the first to investigate how many of those who attempted suicide finally killed themselves. He also concerned himself with the mental state at the time of the follow-up. In many other respects the questions studied were the same as those examined by previous writers in relation to suicide.

The present authors began their enquiries into attempted suicide in 1950. During the first two years Dr. I. S. Kreeger co-operated in this work. The plan of these investigations and its first results was presented by one of us (E. S.) to the Section of Psychiatry of the Royal Society of Medicine in London on 13th May 1952 and published in the *Proceedings* of that Society in the same year (1952). In that communication most of the problems, to which the present writers are addressing themselves in this monograph, were briefly outlined. The view was expressed that those who attempt and those who commit suicide constitute two different though overlapping populations. 'There are many questions about attempted suicide to which one would very much like to know the answers. I will mention a few only. What is the relationship between the two populations: those who commit suicide and those who attempt suicide? What is the size of the latter group? What happens to those who attempted suicide? How many kill themselves later, and what types are liable to do so? How does the suicidal attempt affect the patient's mental state? If suicide has been motivated by inner conflict, what happens to the conflict? If it was motivated by a crisis in human relations, were these modified by the suicidal attempt, and, if so, how? What is the effect of the suicidal attempt on the patient's group and what are their reactions to it? Sociologists have stated that suicide is due to social disintegration and isolation. Do these factors hold good for the suicidal attempt, and, if so, are they influenced by it? Some of these questions are of immediate practical interest for the clinician. The study of others might help us to understand the function of the suicidal attempt in our society.'

The first results of an analysis and follow-up of a group of patients admitted to a London Mental Observation Ward were reported. The final outcome of these and other investigations will be presented here. They were briefly summarized on the occasion of a symposium on suicide (Lewis, A., Moll, Sisler, Stengel, 1956).

The present writers stressed the need to consider attempted suicide without preconceptions about its aim and biological significance, which hitherto have been regarded to be self-destruction only. It became obvious that this could not be so. 'The self-injury in most attempted suicides, however genuine, is insufficient to bring about death, and the attempts are made in a setting which makes the intervention of others possible, probable, or even inevitable. There is a *social* element in the pattern of most suicidal attempts. Once we look out for that element we find it without difficulty in most cases. There is a tendency to give a warning of the impending attempt, and to give others a chance to intervene. We remember how few suicidal attempts are carried out in circumstances that would make death certain. If we think in terms of a social field we may say that those who attempt suicide show a tendency to remain within this field. In most attempted suicides we can discover an appeal to other human beings. Psychopathological studies have shown that this particular appeal is also a powerful threat. If it is overlooked or remains unheard, or if it is smothered by the force of the self-destructive impulses, the suicidal attempt will succeed. The outcome, therefore, depends on whether there is a receiver for the appeal. Sometimes he has to be shouted for. We regard the *appeal character* of the suicidal attempt, which is usually unconscious, as one of its essential features, but it certainly is not the only one that determines its purpose. If one had to design a pictorial symbol for attempted suicide one would present this act as Janus-faced, with one aspect directed towards destruction and death, and the other towards human contact and life. There is another fundamental feature in attempted suicide which may be called its *ordeal character*, the term ordeal being used here in its original sense, i.e. of an ancient trial in which a person was subjected, or subjected himself, before the community, to a dangerous test the outcome of which was taken as divine judgment. The so-called failure of a suicidal attempt is usually accepted without demur, at least for a time, and in a considerable number of patients the depression disappears immediately after the attempt. From the biological aspect we may regard the suicidal attempt as a catastrophic reaction to an intolerable social and emotional situation. Within this wide definition fall suicidal attempts to spite others, attempts which aim at reunion with someone who has died, and those outbursts of aggression against the self and the environment in the course of which the boundaries between them have temporarily become blurred.'

A special chapter of the report was headed 'Effects of Suicidal Attempts on Human Relations' and a variety of changes in the individual's relationship to his environment as a result of the suicidal attempt were pointed out: admission to hospital, changes in relationship to the group, prevention or hastening of breaks in human relations,

etc. It was also pointed out that the frequency of suicidal attempts as compared with the incidence of suicide appeared to depend on the attitude of the society to the individual: in a hostile society suicide is frequent but attempted suicide rare. This was tentatively related to the lack of response to an appeal inherent in most suicidal attempts. Most of the points briefly mentioned in that paper will be discussed more fully in this monograph.

In the same year as the paper of the present writers, a monograph *Suicide* by E. Ringel (1952) appeared. This reported an investigation into 745 attempted suicides admitted to the Vienna University Hospital in 1949. Ringel regarded suicidal acts as the expression of a neurotic attitude originating in unfavourable relationships in childhood, especially with the parents. In this respect he confirmed von Andics' observations (1947), and believed that every suicidal act is preceded by narrowing of consciousness, increased aggressiveness and escape into phantasy. This combination he called 'the pre-suicidal syndrome'. He observed that after the suicidal attempt the individual has an increased tendency to turn towards his fellow-men and that it is important to take notice of this fact. Bond (1931) made the same observation. In Ringel's view those who commit suicidal acts have an abnormal attitude to the values accepted by society and he suggested a test to measure this. Finally, he reported the results of a short-term follow-up of suicidal attempts, in which he found that of 2,879 patients admitted to hospital because of attempted suicide between 1948 and 1950, only one, a schizophrenic, had committed suicide by August 1951. Ringel finally discussed the case for psychotherapy and claimed that the surprisingly small number of suicides was partly due to the treatment and attention they received. Recently Hoff and Ringel (1956) discussed the circumstances and measures which militate for and against a repetition of suicidal attempts. They took up some of the problems raised in the first report on this research (Stengel, 1952) and analysed for a series of patients the effects of the suicidal attempts on their human relations.

Harold Hove (1953) of Copenhagen reported on a follow-up of 500 suicidal attempts with narcotics admitted to a psychiatric department. 24 persons (4·8%) had committed suicide within two to three years. One-fifth of the total had repeated the attempt, but under half of their number only had been re-admitted to hospital. 9·3% of the whole group were alcoholics and 14·8% were drunk at the time of the attempt.

Pierre-B. Schneider (1954) of Lausanne has studied attempted suicide from various angles and has also carried out follow-up examinations. He expressed the opinion that the statistical aspects had been overstressed by many authors, at the expense of the psychological. In his view there was no difference in the degree of suicidal

tendencies of the two sexes, but men were more vulnerable to suicidal acts, as they were to disease and accidents. He formulated a general biological law stating that the male clung to life less and was less resistant than the female, which was in keeping with the more active biological rôle of the male as compared with that of the female. Schneider also reported on the results of catamnestic studies in a series of cases admitted to the medical, surgical and psychiatric university hospitals of Lausanne in the years 1933 to 1940 ; the mortality among the group, which consisted of 372 patients, was higher after 10 years than among the rest of the population. The difference was not due solely to deaths by suicide, but to other factors, such as age in women, alcohol abuse in men, and to mental diseases. The number of suicides among the group was 34 after ten years, i.e. less than 10%, and 44 (11·8%) after 18 years. He attributed the excessive suicidal risk among attempted suicides to abnormal personality traits, especially to psychopathy. The result of nosological analysis of his material was in keeping with that of previous writers. Schneider's follow-up appears to cover a longer period than that of other authors. He called the total number of those admitted to hospital because of attempted suicide the ' minimum number of attempted suicides '. He realized that this number was lower than that of the suicides registered in the same area and hazarded the guess that the real incidence of suicidal attempts was twice to three times greater. If the group represented only a minority of the attempted suicides in the area concerned it can hardly be taken as a representative sample, and all generalizations derived from statistical analysis of it are dubious. Schneider's group of suicidal attempts differed from those of other workers in that the majority of his patients were male, whereas it is generally accepted, rightly or wrongly, that among attempted suicides females outnumber males. Enquiry into the frequency of suicidal attempts observed in the canton of Vaud met with a collective resistance on the part of the medical practitioners : of 2,000 questionnaires sent out by Schneider only 27 were returned. This illustrates the difficulties of such studies.

Schmidt, O'Neal and Eli Robins (1954) surveyed 109 persons who attempted suicide admitted to the St. Louis City General Hospital during the first half of 1953. They classified the attempts into serious and not-serious. A serious attempt was one in which the patient had either done himself serious physical harm (' medically serious ') or in which the psychiatrist had regarded the suicidal intention as serious. Two patients who made ' successful ' attempts two weeks after their admission—one in a mental hospital—had been classified in the serious group. The authors regard the risk in manic-depressive patients as great, in patients with psychopathic personality or chronic alcoholism as small. They do not believe that psychiatric training

is required for the correct allocation of patients to the serious or non-serious groups. In their view those whose suicidal attempts are classified as serious should be treated in hospital, but this is unnecessary for the other group, unless the patients suffer from manic-depressive illness or dementia. The follow-up period extended only over four to eleven months after the patient was studied.

Batchelor and Napier (1953, 1954) made a psychiatric analysis of 200 consecutive admissions on account of attempted suicide observed in an Edinburgh General Hospital. They stressed the frequency of psychopathic states, and noted a high incidence of broken homes in the history of those people: the term 'broken home' was used to imply physical, mental or moral deprivation in the child-parent relationship. Childhood is interpreted 'as the period from birth up to but not including the 17th birthday'. Other aspects studied by Batchelor and Napier were the frequency of suicidal attempts in old age, the problem of repeated suicidal attempts and the rôle of alcohol. They also reported on the results of a one-year follow-up of their patients: probably four (2%) had killed themselves. Batchelor and Napier regarded their material as a representative sample from an urban population. They believed that 'the large majority of all suicidal attempts occurring in the city of Edinburgh are admitted to this hospital'. This would mean that attempted suicides in an urban population of at least 500,000 would not greatly exceed 67 during a year, i.e. not much more than the expected number of suicides. But it is likely to be much higher, in which case the representative character of Batchelor and Napier's sample becomes uncertain. Ettlinger and Flordh's (1955) series is open to similar doubts.

This critical survey of the literature is far from complete. It is evident that recent research has aimed at contributing to the knowledge of suicide by investigating problems which cannot satisfactorily be studied after the death of the subject: i.e. motives, intent and predisposition to suicidal acts. There has been considerable progress since Gaupp (1905) distinguished between motives and causes. In addition, the incidence of suicide among those who have attempted suicide, has been investigated. Research into attempted suicide, therefore, has largely been pursued with the aim of aiding that into suicide. Most writers appeared to be of the same opinion as Dahlgren who wrote: 'Even if these cases, the attempted suicides, do not rank equal with the suicides in all respects, for instance with regard to causes, etc., they may nevertheless yield some data of importance for the comprehension of the suicide problem.' Siegal and Friedman's (1955) paper, which is an exception to this rule, will be referred to later in this book.

Chapter 3

THE PURPOSE AND PLAN OF THIS RESEARCH

IT IS OUR CONTENTION that attempted suicide presents problems peculiar to itself, in addition to those it has in common with suicide, and it is the main purpose of this monograph to state these problems and to contribute to their elucidation.

To establish the relationship between attempted suicide and suicide it is necessary to follow-up persons who have made suicidal attempts. If the clinical impression that only a small minority kill themselves should be confirmed, the case for regarding suicidal attempts as a group of its own would be considerably strengthened.

Suicidal attempt will be viewed as a social behaviour pattern ; the relationship of the individual to the social environment in the course of the suicidal attempt will be studied, and, if possible, compared with that in suicide.

In the causation of suicide, social factors are known to be of great importance ; but the effects of a suicidal attempt on the person's social relationships have never been studied systematically. It is suggested that suicidal attempts have a considerable effect on these relationships. This assumption will be tested by the retrospective study of the social effects of attempted suicide in the patients subject to the follow-up investigation. The reactions of the human environment and of society as a whole to the suicidal attempt will be explored.

CHAPTER 4

SUICIDE AND ATTEMPTED SUICIDE IN GREATER LONDON

IT HAS BEEN SAID that the number of registered suicides represents only a proportion of the real incidence. Zilboorg (1936) has even gone so far as to declare those figures useless. There is no doubt that some deaths by suicide are not included among them, e.g. those supervening some time after the act of injury; deliberate concealment is another source of inaccuracy, and so are suicides recorded as accidents, quite apart from deaths due to an unconscious wish to die. However, there is reason to believe that the degree of inaccuracy of the official suicide rates is fairly constant and that the majority of consciously intended suicides are registered. The same cannot be expected of the official rates for attempted suicide. In England and Wales every attempt at suicide ought to be reported to the police, but it is well known that this does not occur. It is nevertheless interesting to compare the figures for attempted suicide and suicide registered in the Metropolitan Police District (Greater London) which has a population of over 8·3 millions.

TABLE 2

Registered Suicides and Attempts in the Metropolitan Police District 1938–1951

Year	Suicides			Attempted Suicides		
	Men	Women	Total	Men	Women	Total
1938 . .	617	337	954	380	383	763
1939 . .	548	330	878	344	364	708
1940 . .	548	283	831	283	299	582
1941 . .	396	234	630	232	212	444
1942 . .	351	238	589	200	214	414
1943 . .	339	241	580	225	287	512
1944 . .	377	198	575	241	227	468
1945 . .	379	246	625	271	289	560
1946 . .	444	278	722	322	374	696
1947 . .	445	310	755	378	394	772
1948 . .	541	322	863	426	554	980
1949 . .	508	306	814	454	523	977
1950 . .	459	287	746	439	505	944
1951 . .	476	299	775	418	539	957

Table 2 shows the number of suicides and attempted suicides registered in the period of 1938–1951. Fig. 1 shows the rates for suicide and attempted suicide per 100,000 of the population aged 15 years and over, registered during that period.

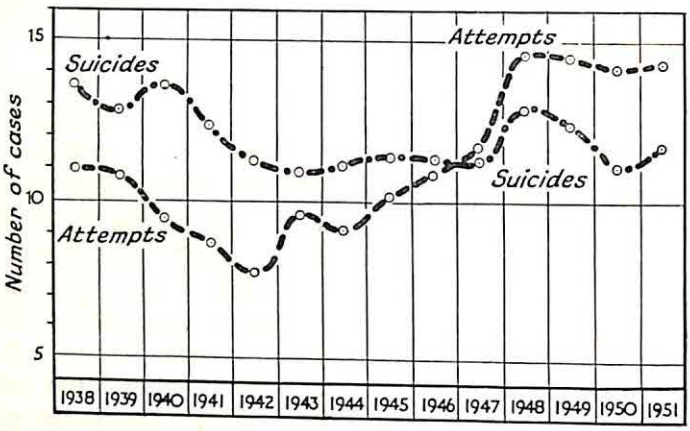

FIG. 1. Rates for Suicides and Suicidal Attempts per 100,000 of Population Registered in the Metropolitan Police District, 1938–1951.

As the figures for attempted suicide represent obviously only a fraction of the real incidence, it is interesting that over long periods they followed the trend of the suicide rate fairly closely. Until 1948 the former was lower than the latter. Both rates showed a marked decline during the war years, a well-known peculiarity of suicide rates. As elsewhere, more men than women committed suicide in London, but registered attempts were more frequent among women.

TABLE 3

Distribution of Age-Groups among Suicides and Attempted Suicides Registered in the Metropolitan Police District in 1951

Age-group	Suicides			Attempts		
	Men	Women	Total	Men	Women	Total
Under 25	13	8	21	74	99	173
25 and under 35	41	26	67	86	108	194
35 and under 45	72	51	123	86	109	195
45 and under 55	111	74	185	64	97	161
55 and under 65	86	74	160	54	63	117
65 and under 75	90	42	132	40	40	80
75 and over	63	24	87	14	23	37
All ages	476	299	775	418	539	957

Table 3 shows the contribution of the various age-groups to the suicidal acts registered in 1951. The peaks were later among suicides than among registered suicidal attempts. In recent years drugs have been used much more frequently than previously. Fig. 2 shows this clearly. The increase in the use of drugs for suicidal acts began during the war, but 1948 brought a dramatic rise. This might have

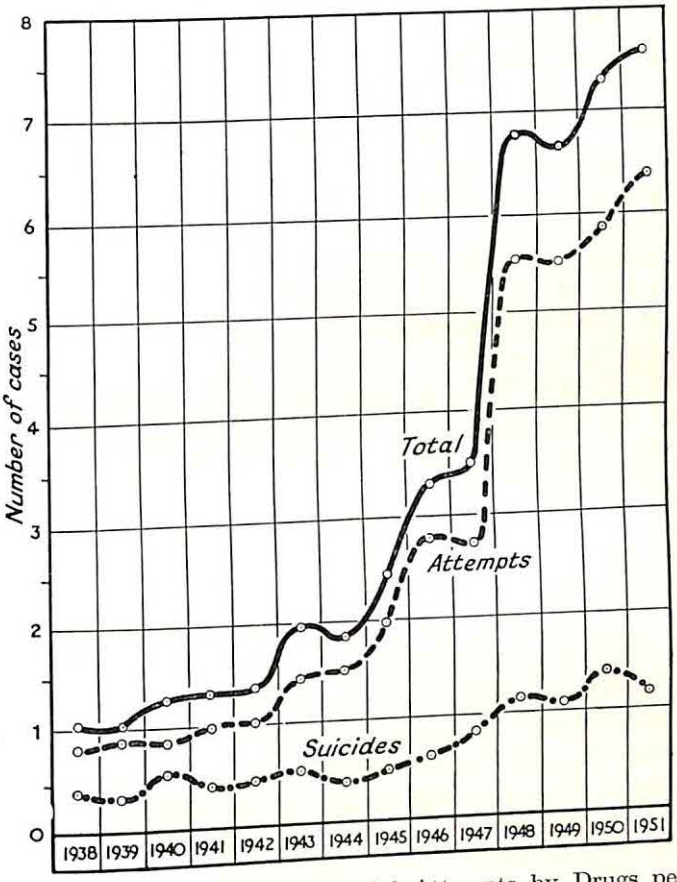

FIG. 2. Rates for Suicides and Suicidal Attempts by Drugs per 100,000 of Population Registered in the Metropolitan Police District, 1938–1951.

been related to the easier availability and consequent greater consumption of sedatives since the institution of the National Health Service in that year. The increased use of drugs, mostly narcotics, for suicidal acts, at least for those registered, had a remarkable effect on the relationship between suicide rates and the rates for registered attempted suicide. Though the latter, and therefore the total for both groups, rose steeply, the incidence of suicide through drugs showed a negligible rise only. For the first time registered attempts outnumbered suicides (Fig. 1). Table 1 demonstrates that the total

suicide rate failed to show a corresponding increase. This apparent paradox is, according to the Statistical Branch of the Metropolitan Police (1950), due to the fact that ' drugs proved the least effective method, and the steady post-war reduction of the percentage of successful suicides was due to the increasing commonness in their use ', which has been associated with a decline in the use of other methods. Whatever may be thought, therefore, about the increased consumption of hypnotic sedatives for which the National Health Service has been responsible, it has not caused a rise in the suicide rate as a whole. It may even be argued that increasing familiarity with hypnotics, by indirectly reducing the use of other methods such as coal gas, might have helped to keep the suicide rate at a low level, even though the number of suicidal deaths through hypnotics has gone up slightly.

The tables and graphs contained in the report of the Statistical Branch of the Metropolitan Police, show not only the figures for suicide and attempted suicide, but also the total of both, which, in the words of the report, ' is thought to reveal the true incidence of the suicide problem '. Some workers have attributed considerable importance to that total and even based far-reaching theories on it (see p. 24). The questionable nature of the statistical data has already been pointed out, and the totals for Greater London have not been reproduced, except in Fig. 2, where it was technically impossible to omit them.

It may be thought that the comparatively small number of suicidal attempts which came to the knowledge of the authorities in London was due to the fact that a suicidal attempt is still officially a punishable offence in this country, although only a small proportion of ' offenders ' are actually charged. However, comparable figures in other countries have been equally small and show the same relationship to the suicide rate. Differences in the legal status of the suicidal attempt, therefore, appear to play little part in keeping the numbers registered at a low level. Obviously other factors favouring secrecy and concealment, and common to all countries, are much more important.

There is evidence that the figures for registered attempted suicide represent only part of the real incidence. Almost daily, psychiatrists working in hospitals and out-patient clinics, see patients who had made suicidal attempts, often of a serious nature, which had not come to the knowledge of the authorities and could not therefore have been included in the registered figures.

The following observation proves the unreliability of the London figures for attempted suicide: among 138 patients admitted to a Mental Observation Ward during 1946 (Group I of this research), the police had intervened in 59. But only 43 of those had been reported as suicidal attempts and had been included among the 696

instances of attempted suicides registered for that year. In respect of the other 16 the intervening police officer apparently had not formed the opinion that the incident was a suicidal attempt. However, among them were seven that would generally be regarded as serious medically. But even if all cases in which the police had been involved had been found in the register of suicidal attempts, they would still form only 42% of the total number admitted to that observation ward because of attempted suicide during 1946. Of the other groups examined, too, a minority only were known to the police. However, it does not require such proof that the known figures in London, as well as in other places, represent only a small part of the real incidence of suicidal attempts. It would be clearly absurd to assume that in an urban population of over 8 millions, only 696 persons should have attempted suicide during the course of a whole year (1946). Though figures such as these are obviously no indicators of the incidence of attempted suicide, their relative constancy is nevertheless remarkable. They may represent a certain section of suicidal attempts and the fluctuations in the size of this section may indicate fluctuations in the number of persons who make suicidal attempts. But even these assumptions are purely hypothetical.

The incidence of suicidal attempts will never be known, but it is certainly several times, if not many times, the number of suicides. The Metropolitan Life Insurance Company of New York, which, like other similar institutions, keeps a careful watch on the suicide rates, has also given attention to the incidence of suicidal attempts. In an article entitled 'Suicides that Fail' (1941) it was stated that in the United States more than 18,000 people a year kill themselves and probably another 100,000 make unsuccessful attempts, which would be equivalent to a ratio of rather less than six attempted to one completed suicide. The Editor of the *Statistical Bulletin* of the Metropolitan Life Insurance Company stated* that this estimate was based 'for the most part on data from the police reports of Los Angeles and Detroit since data of this kind were not available for other cities. A recent check of the ratio with data reported by Detroit had revealed that it still held true for the years 1948 to 1950.' For Greater London, an incidence of attempted suicide six times that of suicide would mean that in 1946, with the number of suicides reported as 722 (Table 2), the number of attempted suicides would be 4,332, i.e. about 83 a week among a population of over 8 million. The number of attempted suicides registered was actually 696.

It has not been possible to ascertain what methods of registration are at the disposal of the authorities in the American cities mentioned. Although their figures for attempted suicide appear to be much more realistic than other comparable data available, its real incidence will

* Personal communication.

remain unknown, like that of other acts which for various reasons tend to be concealed. The person who has made the suicidal attempt and the members of his group, who usually feel guilty for having allowed it to happen, are equally anxious that it should not become known.

It may appear that the question of the incidence of suicidal attempts has been unduly laboured here, but it is important to consider this problem carefully before discussing the relationship between suicide and attempted suicide. If the number of attempted suicides is many times that of suicides, this would be a strong reason for treating the two groups as different though related. There are several other reasons in favour of such an approach, but they will be discussed later.

Chapter 5

THE SPECIAL CHARACTER OF THE AVAILABLE SAMPLES OF SUICIDAL ATTEMPTS

If the number of attempted suicides registered or resulting in admission to hospital is only a fraction of the suicidal attempts in the general population, the majority remaining unknown, no such group can be representative of those who attempt suicide. Whether a suicidal attempt results in admission to hospital depends on a variety of circumstances of which the seriousness of the injury is but one. With many patients admitted to hospital, especially to psychiatric wards, the injury is slight. Much depends on the reaction of relatives or friends which may be quite irrational.

The following examples from the literature demonstrate the diversity of the case material analysed by various authors for the sex ratio alone. It is generally accepted that among attempted suicides women by far outnumber men.

Lendrum (1933) studied 1,000 consecutive admissions for suicidal attempts to the Detroit Reception Hospital; 363 only were men. Hopkins (1937) surveyed similar admissions to the Liverpool Mental Observation Ward during a four-year period; among 656 patients, the male/female ratio was 6/5. Sievers and Davidoff (1942, 1943) made a comparative study of 150 patients admitted to a psychiatric hospital and an equal number admitted to a general hospital; the sex ratio in the former was 61 males to 89 females, in the latter 59/91. Dahlgren's (1945) series comprised 102 men and 99 women admitted to the medical and psychiatric wards of the Malmö General Hospital. Ringel (1952) analysed the successive admissions for attempted suicide to the Vienna University Psychiatric Hospital in 1949; 291 were males and 457 females. The corresponding figures for 1954 were 428 and 454 respectively (Hoff and Ringel, 1956). Schmidt *et al.* (1954) surveyed 109 patients admitted for attempted suicide to the St. Louis General Hospital; 49 were men, 60 were women. Batchelor and Napier (1954) found that, of 200 successive admissions to the Observation Ward of the largest general hospital in Edinburgh, 92 were male and 108 female. Pierre-B. Schneider's (1954) series comprised 196 men and 176 women. Of Ettlinger and Flordh's series 44% were male, i.e. as many as among the general population of Stockholm. In the first series of the present writers (Stengel, 1952) there were 74 men to 64 women.

Differences in the sizes of the diagnostic groups forming the material

analysed by various authors were considerable and could not be accounted for solely by differences in diagnostic criteria, though these were no doubt responsible for the great variations between the number of psychopaths, reactive depressions, etc. In comparing the representation of the different diagnostic groups in the various series published, it must also be kept in mind that the allocation of individual patients to those groups probably differed, even when there was no diagnostic ambiguity. A person who has had several epileptic fits in his life and attempted suicide in a state of reactive depression, would by some be allocated to the epileptics, by others to the category of reactive depression. The same applies to mental defectives and psychopathic personalities. Clearly it is impossible to compare the various groups studied. The same applies to the disposal of the patients. The number discharged within a few days or weeks depends not only on their condition, but also on the availability of suitable hospital accommodation and other factors.

The impossibility of comparing data collected by various authors restricts the value of their work and hampers progress in research.

Chapter 6

PRESENTATION OF DATA

Numerical Data. This study does not aim at a statistical analysis of the data collected ; the doubtful value of an analysis of unrepresentative samples has already been pointed out. Nevertheless, numerical data will be presented to illustrate the character of the groups studied, and, where possible, to compare them. As percentages tend to give an impression of scientific exactitude which cannot be achieved with material such as this, their use has been kept to a minimum, and no general conclusions should be drawn from the frequency with which certain sequelae of suicidal attempts were observed in the groups investigated.

Case Reports. To illustrate these sequelae, a number of case reports will be presented, but certain precautions against identification have had to be taken, by omitting or masking personal data. Inevitably, a good deal has been lost which would have made the reports more interesting. It is hoped, nevertheless, that the points relevant to this presentation will become apparent. No such strict safeguards are called for in reports of patients who have committed suicide, for most of the reasons making secrecy desirable in attempted suicide do not apply to cases which came before a Coroner's Court.

Diagnostic Classification. The following seven diagnostic groupings were made : schizophrenia ; manic-depressive illness and involutional depression ; senile depression ; other depressions (reactive, neurotic) ; organic reaction types (confusional states, dementia) ; psychopathic reaction ; unknown. Depressions have been called reactive when an overt psychic trauma of considerable severity precipitated them and provided the main motive for the suicidal attempt. It was often impossible to differentiate them from neurotic depressions, i.e. those developing in a neurotic illness, such as anxiety state, sometimes without, or with comparatively slight, provocation.

The diagnostic classification employed here was identical with that generally used in the observation wards and mental hospitals. It has the disadvantage of being one-dimensional and focuses on the conditions which led to the patient's admission. Other authors have used different criteria to classify patients who had attempted suicide.

Often a single diagnosis cannot do justice to the clinical condition : a diagnostic formulation such as ' reactive depression in a mentally defective epileptic ' would be required. In the grouping here mental deficiency and epilepsy do not appear although representatives of

each category were among the series. Most had been included among the reactive depressions.

The category ' other depressions ' includes patients with abnormal personalities. They could perhaps have been listed among ' psychopathic reactions ', but this category was reserved for patients with psychopathic personalities in whom the suicidal attempt had been a sudden response to a stressful situation and depression had not been marked. It included most of the attempts by alcohol addicts and also by some epileptics.

Other Factors. Each group has been analysed for the factors usually studied, i.e. age distribution, marital status, diagnosis, etc., but no systematic statistical evaluation has been attempted. This would have been unprofitable and possibly misleading in view of the doubtful representative character of the groups, and many of the numerical data will illustrate the limitations rather than the value of statistics in the study of attempted suicide. Wherever possible, corresponding data concerning several or all groups have been presented together.

The men were also grouped by social class ; the women could be classified only in Group II where more detailed information was available. The grouping was that employed by the Registrar-General for England and Wales ; viz. I. Professions, etc. II. Intermediate occupations. III. Skilled occupations. IV. Partly skilled occupations. V. Unskilled occupations.

Chapter 7

THE GROUPS STUDIED

Definition of Suicidal Attempt. Every act of self-injury consciously aiming at self-destruction was regarded as a suicidal attempt. Verbal suicidal threats or suicidal gestures were not included. Some workers classify suicidal attempt resulting in only slight injury with no danger to life as suicidal threats or gestures, but the present writers have decided against this, as the degree of self-inflicted injury is no reliable measure of suicidal intent. The definition of suicidal attempt is bound to be arbitrary, and for this reason the term has been used in its conventional meaning, which relies on observed behaviour and its effects and on statements regarding conscious motivation. Thus, acts or behaviour patterns unconsciously aiming at self-destruction have not been considered here.

Focus on Special Problems in Different Groups. The impossibility so far of finding a truly representative sample of attempted suicides imposes caution in generalizing from statistical data based on the available material. It also makes it necessary to study as many samples as possible to arrive at even tentative conclusions. Furthermore, no single series is suitable for the study of all problems one wishes to investigate. For an enquiry into the fate of people who have attempted suicide, a group whose suicidal attempts had been made years ago is most suitable, but it is less valuable for a study of motives and degrees of suicidal intent, which are better investigated immediately after the suicidal attempt. If research is thus focused on the aspects to the elucidation of which each group appears most suitable, a true composite picture of the suicidal attempt is more likely to emerge than if equal attention is paid to all problems in one series. The writers of this monograph have, therefore, not aimed at extracting all data relevant to the problems of attempted suicide from each series chosen for study. They were selected with special problems in mind, i.e. those for the study of which they were suitable.

The results of the investigations into five groups of attempted suicide are presented. Table 4 shows their size, clinical character, and sex ratio, together with the main aspects specially studied in each series. It also includes a series of suicides as a control group for certain features common to suicide and attempted suicide. All series consisted of unselected successive admissions to three different types of hospitals over certain periods.

TABLE 4

The Six Groups Studied and the Special Problems Investigated in each Group

Designation of Sample	Hospital	Period	Size of Group	Male	Female	Special Problems Investigated
Group I . .	St. Francis' Observation Ward	1.2.1946–31.1.1947	138	74	64	Follow-up, with special consideration of the social effects of the suicidal attempt.
Group II . .	Bethlem Royal and Maudsley Hospital	1.7.1949–30.6.1950	72	20	52	As Group I, also : The suicidal attempt as a social behaviour pattern. Comparison with the total hospital population.
Group III .	St. Francis' Observation Ward	1.1.1953–31.12.1953	167	66	101	The suicidal attempt as a social behaviour pattern. Dangerousness and intent.
Group IV .	St. Pancras' Observation Ward	1.1.1953–31.12.1953	177	97	80	A mental observation ward serving a different part of London. Comparison with Groups II and III.
Group V . .	Dulwich General Hospital	1.1.1951–31.12.1953	76	26	50	Comparison of this general hospital group with the mental observation ward groups. Dangerousness and intent. The suicidal attempt as a social behaviour pattern.
Group S . .	Suicides subject to inquests before the North London Coroner's Court	1.1.1953–31.12.1953	117	73	44	Comparison with groups of attempted suicide. The social aspects of the act of suicide.

Chapter 8

METHOD OF FOLLOW-UP INVESTIGATION

The investigators tried to interview each patient of the series followed up, i.e. Groups I and II, and also to obtain information from relatives or friends, and, if necessary, from employers, if the patient consented. The patients were interviewed by one of the doctors (most by Dr. I. Kreeger), and the relatives by the psychiatric social worker (N. G. Cook).

The main purpose of the follow-up was to ascertain the patients' state of health and the immediate and long-term effects of the suicidal attempt on their relationship to their environment. Other aspects explored were the realization of the legal implications of suicidal attempts, religious attitudes, etc.

The follow-up of Group I was carried out in 1951 and 1952, i.e. 5–6 years after the suicidal attempt which led to admission in 1946. Only a small proportion were in a mental hospital at the time of the follow-up. Group II was investigated in 1953, i.e. 3–4 years after the attempt. The patients proved a rather elusive group and the difficulties of tracing and interviewing them were sometimes considerable. In Great Britain there is no residential register and it often required much patience and ingenuity to find a patient who had changed his address since 1946.

An informal letter to a relative preceded the interview. It stressed that they were invited to give voluntary co-operation and that their contribution might help others in the future, but the suicidal attempt was not mentioned and during the interview also they were not told that the principal interest was in the suicidal attempt, the approach being that of a general follow-up enquiry. The patients were interviewed either in the Out-patient Department of the Maudsley Hospital or in their own homes, except for those seen in mental hospitals. The psychiatric social worker, who made the first approach by letter, saw most of the informants in their own homes, as visits were regarded as essential for full information. Our wish to interview the patient was not raised until the end of the interview, when the relative's help in this was sought. There were 15 refusals in Group I, mostly from a fear that re-opening the past might harm the patient. In Group II there were only 2 similar refusals.

The investigators tried to obtain as much information as possible about the patient's history, personality and social background, the causes and constellation of the suicidal attempt which led to the

admission in 1946, and the events after the attempt. Its effects on the patient's mental state and social adjustment, as well as his and his relatives' attitudes to the attempt, were explored. Marked changes in his human relationships or his and his relatives' modes of life were studied and the rôle of the suicidal attempt in bringing about those changes was considered. The social situation at the time of the follow-up was reviewed.

The doctor and the psychiatric social worker proceeded in accordance with the following two schemata. More ambitious and detailed ones with which the authors originally set out in their follow-up investigations contained many items which it proved impossible to study systematically in the material available, and in the schemata presented below only those items have been included about which it was possible to obtain information for the majority of patients. It is hoped to use the more comprehensive versions on another occasion.

When a personal interview could not be arranged, a routine follow-up questionnaire sent out by the Professorial Unit in the Bethlem Royal Hospital and the Maudsley Hospital was used.

The other sources of information used when necessary were : Board of Control for England and Wales for admissions to mental hospitals, the Registrar-General's Office, Somerset House, for ascertaining whether and when a patient had died.

Schema I for Follow-up Investigation of Attempted Suicide (for Interviewing Psychiatrist)

Name, age at attempt, marital status, religion, nationality, address and that of next of kin.

Family history. Parents : age, age at death and cause of death, age of patient at their death. Occupation. Health. Personality, including social deterioration, e.g. alcoholism, prison, brutality. Siblings : number, sex, position of patient, health. Abnormal environment in childhood : parents unavailable due to occupation, absences, broken home, desertion, divorce, separation. Step-parent, adopted, orphanage. Marked parental discord or other abnormal environmental stresses or relationships in childhood. Social position of family. Mental disorder, alcoholism, etc., in family. Suicide in family.

Personal history. Development. Marked neurotic symptoms or ill-health in childhood. Education, ability, standard reached. Occupation and work record till first attempt. Unemployment or financial stresses. Housing conditions. War service—type, rank, injuries, adjustment, date of demobilization, seen by psychiatrist.

Psychosexual development. Menses. Sexual adjustment. Civil status—single, married, divorced, widowed, separated, cohabiting, previous marriage. Marital adjustment. Children—age, sex, health.

Previous personality, with special consideration of social adjustment, habits, alcohol, tobacco, drugs. Delinquency, acts of violence.

Medical history. Previous physical illnesses, previous mental health including fugues, accident proneness, self-mutilation, etc. Previous attempts.

Events leading to attempt. Ascribed causes and immediate precipitating event (patient and informants).

Attempt. Date, time, method. Social constellation: was the patient together or near people at the time of the attempt? Who intervened and what was the likelihood of intervention? Physical effect.

Sequence of events immediately following attempt. Mode and date of admission. Mental and physical state. Diagnosis.

Disposal. Transfer to mental hospital as voluntary, temporary or certified patient. Transfer to general hospital. Other, including discharge home. Course of illness, treatment, date of discharge. Diagnosis on discharge.

Duration of incapacity following attempt. Period of time before patient resumed employment or could take up usual responsibilities.

Police action. Court case.

Subsequent illnesses. Personality changes.

Subsequent suicidal attempts.

Interview with patient. Date, place.

1. Mental state.
2. Retrospective account of cause of attempt.
3. The patient's views on the effects of admission to hospital.
4. Present attitude to attempt, including religious, social and legal aspects.
5. Attitude of relatives and others to the attempt.
6. Changes in patient's human relationships and environment since attempt. The patient's views on the rôle of the attempt in bringing about changes in (*a*) social adjustment, (*b*) work and financial circumstances, (*c*) emotional adjustment, (*d*) sexual and marital adjustment—change in status, further children, etc., (*e*) change in mode of life of members of his family or friends.
7. Effect of the attempt on the state of conflict leading up to it—gains and losses.
8. Present total situation.
9. Plans for the future.

Schema II for Follow-up Investigation of Attempted Suicide

(for Psychiatric Social Worker)

Informant. Description. Intelligence, reliability. Bias and attitudes towards patient, before and since the suicidal attempt.

Family history, as in Schema I, with emphasis on patient's relationships with other members.

Personal history and previous personality, as in Schema I, including special behaviour patterns throughout life.

Medical history, as in Schema I. Attitude to health.

Social and other factors and precipitating events leading to the attempt.

Social setting of the attempt, as in Schema I.

Patient's stated reasons for attempting suicide (1) immediately after the attempt, (2) while in the observation ward or hospital, (3) at the time of follow-up.

Context of any previous suicidal attempt.

Sequence of events after the suicidal attempt

Police action, as in Schema I.

Admission to hospital, and its effects, with special emphasis on socialization as seen by informants.

Disposal, as in Schema I.

Rehabilitation initiated by hospital, other organizations, interested individuals, or by the patient.

Subsequent re-admissions.

Subsequent suicidal attempts, their causes and contexts compared with the previous attempt or attempts.

Informant's impression of patient's general behaviour immediately after, and since the attempt.

Changes in human relations, environment and mode of life

Within the family. Change of status. Increase or decrease of toleration, consideration, affection, aggression. Alteration of rôles.

Patient's relationship vis-à-vis members of the family or ' special persons '. More or less docile or aggressive. More or less dependent. More or less mature with regard to family responsibility. Acquiescence in alteration of rôles. Change in the amount of jealousy shown.

Within other groups. Relationship to old contacts. New contacts. State of isolation. Changes in recreation, club, church, habits.

Sexual relationships. Effect of suicidal attempt on existing attachments. New attachments. Changes in marital adjustment. Separation or divorce since the attempt.

Attitude to authority. Delinquency.

Changes in adjustment to work. Return to old job or change of job and/or work. Psychological and social significance of this change. Attitudes to employer and workmates. Social status of work compared with that of previous work. Re-training (*a*) on own initiative, (*b*) on medical advice, (*c*) other. Housewife. Changes in skill, standards, interest.

Mode of life, of patient or a member of his family. Changes attributable to the suicidal attempt.

Religious beliefs. Attitude to the suicidal attempt from patient's religious point of view.

Composition of family. ? member has left or died. Changes through other causes.

Financial circumstances, housing. Changes since the attempt and reasons for them.

CHAPTER 9

GROUP I. 138 ADMISSIONS FOR ATTEMPTED SUICIDE TO ST. FRANCIS' HOSPITAL OBSERVATION WARD FROM 1ST FEBRUARY 1946 to 31ST JANUARY 1947

ST. FRANCIS' HOSPITAL is a general hospital in the south-east of London, a residential and industrial area. The observation ward, which can accommodate 82 patients, half for each sex, serves mainly this section of London, but often patients from other parts of London are admitted when accommodation in other observation wards is not available. As the area served by this observation ward does not include districts which are specifically metropolitan, the patients in this ward are unlikely to be representative of the type admitted to such a ward in a big city. They have been compared with those in St. Pancras' Hospital Observation Ward which serves more specifically metropolitan sections of London. This is the series listed as Group IV.

Patients are admitted by a municipal official, the 'Duly Authorized Officer', called in by the general practitioner or relatives or the police, whenever a person's mental state urgently requires psychiatric care. It can therefore be assumed that Group I is fairly typical of those who, as the result of suicidal attempts, are admitted to mental observation wards serving an industrial and residential section of Greater London, and come from the socio-economic strata from which public hospitals generally draw their patients. In comparing Groups I and III, i.e. one year's admissions for attempted suicide to the same observation ward, the difference in the sex ratio springs to the eye: Group I had a male majority, whereas in Group III the sex ratio was the opposite, in keeping with that commonly observed among attempted suicides. Such differences may be due to factors unrelated to the incidence and sex distribution of attempted suicides in the area served by the observation ward. Part of the ward may have been out of use for some time, or the flow of admissions to the male or female section may have been obstructed temporarily: at times an observation ward, or one of its sections, is unable to admit patients because the mental hospitals to which some patients have to be transferred have no vacancies.

Admissions to St. Francis' Observation Ward during the year under survey totalled 1,342. 10·3%, therefore, had been admitted after a suicidal attempt. The case notes, as is to be expected in a busy

reception ward, were not elaborate, and some of the data of interest to this study had when possible to be ascertained retrospectively. As has been pointed out, this particular series was not regarded as suitable for a detailed study of motives and suicidal intent. Usually, statements on those points could be obtained from the patients during the follow-up investigation, but their reliability was dubious owing to inevitable distortions through lapse of time.

Size of Group and Sex Ratio. This is shown in Table 4. There were more men than women, which was at variance with the rule that more women than men attempt suicide. The same atypical sex ratio was observed by Hopkins (1937) in a series of admissions to a mental observation ward at Liverpool. The atypical sex ratio in Group I may have been due to technical reasons of the type referred to above (p. 43). It was reversed in 1953 (Group III, p. 38).

Age-groups. Table 30, p. 107, shows the representation of the various age-groups. There were two peaks among the male patients (age-groups 35–44 and 65–74) and one peak among the females (age-group 25–34). The age distribution in this series is in keeping with observations by others that the known incidence of suicidal attempts in the younger age-groups is comparatively higher than that of suicides.

Marital Status. Table 29, p. 106, shows the marital status of the members of this series at the time of the attempt. Corresponding figures for the general population of the area concerned were not available for comparison. It appears, however, that the proportion of single or widowed persons was comparatively higher than would be expected in the general population, again in keeping with what has been observed with suicide.

Isolation. 31 were living in isolation, i.e. they had no fixed abode, or lived alone or in lodgings or were mobile by nature of their occupation (Sainsbury, 1955). 22·6% of this group, therefore, were living in isolation. There are again no comparable data for the general population of the area from which the series had come, but it is worthy of note that in 1929 about 7% of the general population of Greater London had been found to live in isolation and that Sainsbury (1955) found 27% thus living among the suicides registered in one of the northern sections of London.

The effect of the suicidal attempt on the state of isolation will be examined later (p. 61).

Religion. All major denominations in the general population were represented. 98 of the 138 in this series belonged to the Church of England, 19 were Roman Catholics, 12 Non-conformists, 4 Jews; for 5 the religion was not stated. No information concerning religious affiliation among the general population of the area from which the series was drawn was available for comparison.

The question of their attitudes to suicide from the religious point of view was discussed with the patients wherever possible. Many did not believe in God or an after-life and stated that when they attempted to kill themselves they regarded it as the end. Of those who believed in God the generally held attitude was that suicide was a sin either because it was wrong to take life, or that life was given to them by God and was His to take away. Though believing suicide a sin, nearly all the patients interviewed were sure that they would not go to hell—most claimed that they would not be damned as they did not know what they were doing by reason of mental disturbance. In no case did the patient, at interview, agree that at the time of the attempt he expected to go to a better place—heaven. Some, however, said that reunion with a dear relative was the aim of the attempt, but this reunion was visualized not as a physical one, but rather as being in the same state with the deceased person.

Representation of Social Classes. The grouping was that used in the reports of the Registrar-General and adopted by Sainsbury in his ecological study of suicide in London. The 3 unemployed were omitted. Table 31 (p. 108) shows that among the men the first three classes were under-represented, as compared with the general male population of London, while classes IV and V were over-represented, the proportion of the latter being more than double that among the population of London as a whole. The female patients of this group have not been classified for social class. This is often difficult to establish in females as the criteria of classification are more complicated and often more arbitrary than for men. Of the 64 women, one was a school teacher and 5 had married business men. For 15 who were married, separated or divorced, the profession or trade of the husband could not be ascertained. The rest of the women belonged to the working class. No figures for social class distribution among the general female population of London were available.

The over-representation of the lower social classes among the men in this series does not reflect the composition of the population of the area mainly served. South-east London and the adjacent part of south-west London comprise a number of large suburbs in which the middle classes are well represented.

Modes of Admission. These are shown in Table 27 (p. 105). It is noteworthy that among those admitted from their own homes, women were in the majority. Of the 90 patients transferred from other hospitals, 49 were male, 41 female. The patients had come from 16 general hospitals, 14 in south-east London and 2 in the adjacent area of south-west London. One patient had been brought from a tuberculosis sanatorium and one from an orthopaedic hospital. 10 patients had been brought from the Maudsley Hospital, where 5 had been in-patients, the rest out-patients.

Police Intervention. In 63 cases (38 male, 25 female) of this series, police officers had intervened at some stage. Of these patients, 20 (15 male, 5 female) had come to their notice outside their homes, 2 (both male) had been taken to the police by a relative, and for 41 (21 male, 20 female) police help had been sought from home or lodging. Police officers had assisted here either by arranging admission to a general hospital or by taking the patients directly to the observation ward. The latter group numbered 12, 5 men and 1 woman taken to the observation ward from the street, the river or the police station, and 5 men and 1 woman taken there directly from their homes, apparently because the doctor who would have called the Duly Authorized Officer was not immediately available. Police officers were not only instrumental in admitting patients to general hospitals and directly to the observation ward, but in a number of cases stood by while the patient's admission was arranged through the Duly Authorized Officer. It was mentioned earlier (p. 30) that 16 patients whose suicidal attempts had come to the knowledge of the police had not been registered as such.

Diagnostic Classification. Table 33 (p. 112) shows the diagnostic groupings slightly amended from those in the interim report (Stengel, 1952) in the light of later investigations. The 1952 category of ' neurotic depressions ' is here designated ' other depressions (reactive and neurotic) '. 94 of the 138 patients had been suffering from a depressive condition at the time of the suicidal attempt. The preponderance of psychoses in this series is not surprising as it presents a selection of patients regarded as in need of special psychiatric care and treatment. There were 9 mental defectives in this series (male 6, female 3) : two were also epileptics. There were altogether 13 epileptics (male 6, female 7) in this series. The majority of mental defectives and epileptics were listed among reactive depressions, the rest among psychopathic reactions.

There were 6 puerperal conditions and 3 pregnant women in this series. The diagnoses of the puerperal conditions were : 1 schizophrenia, 2 depressive psychoses, 2 reactive depressions, 1 epileptic. Among the pregnant women were 1 depressive psychosis and 2 reactive depressions, one of whom was an epileptic.

Alcohol Abuse. 7 men and 5 women were alcohol addicts, but there was no chronic alcoholism in this group. (We have adopted the definition proposed by the World Health Organization.) 9, probably 10, men and 1 woman were known to have taken alcohol at the time of the suicidal attempt ; 6 of these men and the woman were alcohol addicts.

These numbers are small and probably incorrect, but it is hardly possible to establish the facts in a group of whom only a minority were admitted directly after the suicidal attempt.

Seasonal Fluctuations. The monthly distribution of attempts over the year was : 10, 12, 13, 12, 20, 10, 16, 3, 11, 13, 6, 12, the incidence, therefore, being highest in May lowest in August. Other investigators have also found the peak in May.

Methods. In this group the methods used were in the following order of frequency : drugs 25% ; wounding 19·5% ; coal gas 18·3% ; hanging and strangulation 11% ; disinfectants and corrosives 9·1% ; jumping from heights 9·1% ; others 8%. Women used less violent methods than men ; wounding was used by 30% of the men but by only 8% of the women ; strangulation 14% men, 18% women ; drugs 19% men, 32% women. This is in keeping with the findings of others. It is of interest to compare the methods used in this series (1946/1947) with those in Group III (1953) which showed a much greater frequency in the use of narcotics (see Table 32, p. 110). The same change had been noted by the Metropolitan Police (p. 30), and attributed to the easier availability of narcotics since the introduction of the National Health Service in 1948.

Motives. No attempt will be made to discuss these, except for stating that physical illness appeared responsible for the suicidal attempt in 11 patients (8·7%) of this series.

The Seriousness of the Attempt. This term has been used in different meanings. Some authors speak of serious attempts when the degree of intent was high, others mean the degree of the danger to life resulting from the self-injury. Robin *et al.* (1954) called an attempt serious when either intent or self-injury, or both, had been of a high degree. Here a different grading will be proposed (p. 84). To discuss this aspect for Group I would not be profitable as it is hardly possible to establish the degrees of intent and self-damage so long after the attempt, but it was carefully explored in Groups III and IV. However, even for Group I it can be stated that frequently there was a marked discrepancy between the degree of self-injury and the severity of the mental disorder. Some of the case reports will demonstrate this.

Previous Suicidal Attempts. The number of patients known to have attempted suicide previously was 31 (22·4%, of whom 15 were men and 16 women). In 6 men and 10 women of these, the suicidal attempt had been recurrent in emotional stress. They belonged to various diagnostic categories. 3 schizophrenics, 4 epileptics, of whom two were probably mental defectives, 3 with depressive psychoses, 3 with reactive depression and 3 psychopathic personalities of whom two were addicts. Of the 4 epileptics, three had been included among 'psychopathic reactions', and one among 'reactive depressions'.

These patients will be referred to again when the question of subsequent suicidal attempts is discussed.

Home Environment in Childhood and Adolescence. For 110 of the 138 patients in this series, information about the home in childhood

and adolescence was available. Twenty-two had lost one or both parents through death or desertion before the age of 6, 12 before the age of 11, and 8 before the age of 16. With a further 18 there had been major parental discord before the patient had reached the age of 16. 50 of the 110 had apparently had a normal home environment.

Only those homes were included among 'major discord' in which there was a history of violent quarrels of great severity and considerable duration which in several instances had resulted in police action and temporary separation. Alcohol abuse alone by a parent was not regarded as sufficient for inclusion in this category.

Workers who have considered this matter agree that parental loss is very frequent in the histories of suicidal individuals, but it is difficult to evaluate these observations as suitable control groups do not exist.

TABLE 5

GROUP I. *Diagnoses for Patients with Broken Homes Related to the Main Diagnostic Divisions of the Whole Group*
(The figures in brackets refer to broken homes under the age of 6)

	Whole Group	Broken Homes
Schizophrenia	13	9 (4)
Depressive psychoses	40	14 (8)
Other depressions	45	12 (6)
Organic confusional state	5	1 (0)
Psychopathic reaction	21	6 (4)
Total		42 (22)

Table 5 shows the diagnoses for the patients with a history of broken homes under the age of 16. They were comparatively most numerous among the schizophrenics even when only the instances in which the disintegration of the family had happened before the patient was 6, were considered. The significance of this finding is impossible to evaluate as histories of broken homes are alleged to be extremely frequent among schizophrenics in general. On the other hand, the proportion of broken homes in childhood among the psychopaths of this series is surprisingly small.

Mental Health in Family. Information was available for 102 of the 138 patients. There had been 'nervous breakdowns' in the families of 39 patients, i.e. in 38% of the known cases. For the majority it was not possible to obtain reliable information about the nature of the illnesses.

Suicides and Suicidal Attempts in Family. A parent or sibling of 4 patients, all male, and another relative of 4 more patients, had died by suicide. Of one patient two brothers, and of another the father

and two brothers had killed themselves. Only with 5 patients had suicidal attempts in the family been recorded. All these figures are unreliable and probably under-estimates.

Results of the Follow-up Investigation

State of the Group at the Time of the Follow-up. At the time of the follow-up, most of which was carried out in 1951 and 1952, the state of the group was as shown in Table 6. Only one death by subsequent suicide could be ascertained. Among the 10 untraced patients suicides may have occurred; none was found in the Register of Deaths. It is possible, however, that they might have been registered under different names or left the country before they died. However, these are remote possibilities, and the untraced patients were more likely to be alive.

Table 6

Group I. *State of the Group at Time of Follow-up*

	Men	Women	Total
Dead:			
Died within 3 months	12	2	14
Died from 3 months to 5 years after admission (1 suicide)	13	9	22
In mental hospitals:			
Patients remaining since attempt	6	4	10
Following re-admission	2	6	8
Out of mental hospital	36	38	74
Untraced	5	5	10
	74	64	138

Disposal. Table 7 shows the modes of disposal. It should be noted that, by statutory regulations, patients are not allowed to remain in a mental observation ward for more than seventeen days. In 2 of the 8 patients who died in the observation ward, the self-inflicted injuries might have contributed to the fatal outcome.

Some of those discharged from the observation ward left against medical advice. They refused to enter a mental hospital as voluntary patients, but their condition did not warrant certification. The patient who committed suicide ten months after discharge had been advised to enter a mental hospital, but refused and was put into the care of his friends whom he very soon left (case 1, p. 51).

Modes of Transfer to Mental Hospitals. Of the 100 patients admitted to mental hospitals, 57 (30 male, 27 female) went as voluntary, 37 (17 male, 20 female) as certified and one male as a temporary patient. 4 patients (3 male, 1 female) were transferred to Tooting Bec mental

TABLE 7

GROUP I. *Disposal of Patients admitted to the Observation Ward and Number of Deaths*

	Men	Women	Total
Discharged from observation ward . .	13	14	27
Transferred to mental hospital . . .	52	48	100
Transferred to general hospital . . .	3	1	4
Died in observation ward	6	1	7
	74	64	138

hospital for the aged. One patient was transferred to a military hospital.

Duration of Stay and Time of Death in Mental Hospital. After three months almost two-thirds of Group I had either left hospital or died.

The total number of those who died within 5 years, in or out of hospital, was 36. One of the two who died 7–12 months after the suicidal attempt was the patient who committed suicide. Table 8 shows that one-third of those who died did so within 3 months of making the attempt. The remaining deaths were distributed fairly evenly over the ensuing 5 years. The mortality ratio for the whole group was 26% at the end of 5 years. This comparatively high mortality rate was partly due to the fact that 35 patients (22 male, 13 female) were over 60 years of age at the time of the attempt, and that a considerable proportion had been admitted with serious physical illnesses. In 11 patients (8·7%) concern about physical illness was given as the main motive for the suicidal attempt. 10 patients were at the time of the attempt suffering from the illness from which they died. Among them were 8 of the 11 who had given physical illness as

TABLE 8

GROUP I. *Time elapsing between Suicidal Attempt and Discharge from Observation Ward or Mental Hospital; Deaths in Hospital*

	Discharged	Died in Hospital
Less than 3 months . . .	76	12
3 to 6 months	14	1
6 months to 1 year . . .	12	1
1 to 5 years	5	7
Patients remaining in mental hospital 10		

their main motive. The illnesses of which the 10 patients died were heart failure (3), cancer (2), pulmonary tuberculosis, diabetes, infective hepatitis, bronchiectasis, septicaemia (1 each).

The mortality rate of those over 60 was only slightly higher than that of a comparable unselected sample of patients: within $3\frac{1}{2}$ years, 21 patients (17 male, 4 female) of Group I had died, i.e. 60% of the total. Post (1951) studied the mortality rate of a series of aged patients admitted to the same observation ward during the same year (1946). He found that of all patients over 60 admitted between February and May 1946, 55·5% had died after $3\frac{1}{2}$ years of admission. In Post's series, comparatively more women than men survived. The same held true in Group I. The only subsequent suicide was that of a man of 69.

Subsequent Suicidal Attempts. 24 (11 men and 13 women) among those traced made subsequent suicidal attempts. 16 (6 male, 10 female) of these had in the past reacted more than once to stress and frustration with suicidal attempts. All but 4 of the 16 made one or two subsequent attempts during the period covered by the follow-up.

The number of attempts by this group outside hospital was 63 and in hospital 18. At least one-quarter of the attempts made outside hospital did not result in admission.

Most of those who repeatedly reacted to stress by attempting suicide had a personality disorder: psychopathy, schizophrenia, epilepsy and mental defect (2). They ceased to react in this way only when they found a new adjustment. Case 16 (p. 60), a schizophrenic, illustrates this.

In the rest of the patients who made more than one suicidal attempt, the recurrence appeared to be due not so much to the abnormal personality as to exacerbation of the illness or recurrence or persistence of excessive environmental stress.

Subsequent Suicide. For only one patient could death by suicide within the period under survey be established. Here the suicidal attempt failed to bring about a change in his circumstances. He refused to remain in hospital when advised to do so and did not avail himself of his friends' invitation to stay with them. The outcome might have been different had he stayed in hospital longer and established new human relationships, even if only temporarily.

Case 1. Mr. F. H., 69, widower. *Reactive depression. Suicidal attempt and subsequent suicide.* The patient, the eighth of nine siblings, came of a stable working-class family. His father's death when he was a few years old meant hardship for the family. He was not very bright at school. He worked as an electrician until his retirement, whereafter he lived on his Old Age Pension and an income from letting rooms in his house. When 20 years old, he was pushed into marriage by his sister, marrying a cousin pregnant at the time by another man. The child was looked after by

others and died at 2½. The patient did not want any children of his own. The marriage was not happy. The patient was extremely jealous of his wife, badgered her, flew into tempers over trivialities and would sulk and at times not speak for a week. He was always very solitary and made no friends. He was meticulous in his work and was thought highly of, but kept apart from his workmates. He had no previous mental illness. He was prone to gastric trouble and was becoming deaf, but at the time of the attempt he had no specific illness, though in the observation ward he was found to have considerable hypertension.

Sister's account on his admission on 19.11.46 : One year earlier his wife had died. He lived on his own, refusing his sister's offer to live with him though she visited him frequently and cooked his Sunday meals. The only other contacts he had were his tenants who caused a good deal of irritation. The precipitating situation appeared to be a quarrel with his sister during a card game ; he became sulky and left the house. She left a note saying that she felt he did not want her but that if he did she would come back. Three days later he attempted suicide : early in the morning he took aspirins and put his head in the gas oven. He left a note on the stairs telling his tenants to beware of the gas and to send for the police. He was found unconscious, taken to hospital and transferred next day to the observation ward. He stated that he had been depressed since his wife died and more so just before the attempt. He wanted to kill himself because no one wanted him.

Within a week he declared that he was no longer depressed, and refused to enter a mental hospital as a voluntary patient. It was decided to disregard the ' slight risk ', and he was discharged to friends who had offered him a home. He promised his brother and sister that he would never repeat the attempt, but his sister said after his suicide that she felt he always regretted not having succeeded. Within three weeks he moved back to his own house as before, his sister continuing to visit him.

Ten months after his first attempt, with no apparent precipitating factor, while his tenants were away he gassed himself. He left a note for the police asking them to remove his body.

Between the two attempts his sister had divulged to him that his wife had often thought of leaving him ; this upset the patient a great deal as he had not known this.

The Effects of the Suicidal Attempt on the Patient's Life Situation and on his Relationship to the Environment. The suicidal attempts in Group I had a variety of effects both immediate and remote. Many were interdependent and overlapping ; their isolation, therefore, is somewhat artificial.

Illustrative examples of several are presented. Most cases demonstrate more than one effect ; they are presented under one heading only, but in short summaries reference is made to all effects in every case.

Temporary Hospitalization and Treatment. The most common effect was the patient's admission to hospital followed by a temporary stay in hospital and treatment. Duration of stay varied considerably, as did treatment, which ranged from superficial psychotherapy to leucotomy. It can be seen from Table 8, p. 50, that after three months

only a minority of those transferred to mental hospitals were still in hospital.

(*a*) *Patients under Psychiatric Treatment.* Among the 138 patients were 15 (5 male, 10 female) under psychiatric in-patient or out-patient treatment for the condition which led or contributed to their suicidal attempts. In these the result was admission or re-admission to a psychiatric unit. The following case illustrates this.

Case 2. Mrs. R. S., born 1904, had since the age of 26 suffered from a severe anxiety neurosis punctuated by periods of depression. Her symptoms were aggravated by the unsympathetic behaviour of her unstable aggressive alcoholic husband. For some years before her suicidal attempt she had become increasingly irritable and depressed with phobias of glass and other sharp objects. Early in November 1945 she was admitted to the Maudsley Hospital but left against advice after three days. Her depression continued and in April 1946 she attempted to gas herself. After the suicidal attempt her husband became convinced of the gravity of the situation, and at the observation ward pressed for treatment, stating that he could no longer be responsible for her as he was certain that she would kill herself if not kept as an in-patient. She was admitted to the observation ward and as she refused co-operation had to be sent to a mental hospital as a certified patient. There her symptoms continued; six months after her re-admission as a result of a relapse while on trial, a leucotomy was performed. She was discharged, recovered, two months later, and held her own in spite of considerable matrimonial obsessional worries. Her anxieties had disappeared and she was more sociable and placid. The marital situation greatly improved during the year after her discharge, but when her husband began to ill-treat her she went out to work. 18 months after discharge she became aggressive to others as well as to her husband, blunt, indiscreet and tactless. In the summer of 1952 she was contemplating legal separation from him, supported by her son, though he considered the faults were equally divided. Three months later she appealed for help in getting a separation, despairing and afraid that she would kill her husband in one of their quarrels. The next month, to her great relief, her husband left her. After some months she accepted him back and found him much more appreciative of her.

Here the suicidal attempt resulted in long overdue treatment in hospital, hitherto obstructed by the patient. Major action, i.e. certification, ensured that she was given treatment, and the suicidal threat also weighed in favour of leucotomy which proved on the whole beneficial.

(*b*) *Patients not under Psychiatric Treatment whose Admission was Precipitated by the Suicidal Attempt.* This group included 42 patients (18 male, 24 female) who had never received psychiatric treatment before the suicidal attempt leading to their admission. 13 others (5 male, 8 female) had received psychiatric treatment in the course of a previous mental illness only. All these had for some time suffered from psychiatric symptoms either not recognized as such or ignored. In those 55, therefore, the suicidal attempt was an alarm signal, instrumental in bringing about admission to hospital. But for their suicidal attempts, the symptoms would have remained untreated with various consequences, one possibly suicide. As this is psychiatrically

one of the most important effects of the attempt, with the most varied consequences for the individual, extracts from a number of illustrative case records will be presented, each demonstrating special facets.

It is noteworthy that there was in this series no patient with a major psychiatric illness in whom the suicidal attempt was the first symptom of the illness. In several the mental condition in which the suicidal attempt was made had been caused by an untreated physical illness, and the attempt led to treatment of the physical illness. Case 5 in particular is an example.

Case 3. John K, born 1912, was inadequate and overdependent. In January 1946 he was much upset when a girl whom he had known for a short time only became pregnant by him. His mother persuaded him to marry her but his attitude was ambivalent and he remained depressed. Owing to extravagance he had no savings on which to start married life ; in addition, his father had recently died and marriage conflicted with his attachment to his mother and his central ambition to take his father's place and make up to her for her poverty and his father's ill-treatment of her. A few days after his marriage he cut his wrists, and was taken to a casualty department where his wounds were stitched and he was sent home. A week later he asked his brother for some rope, with suicidal intentions. Having been refused this, he disappeared and was in a twilight state for about a day. He was taken to the observation ward where he was acutely depressed and suspicious. During the first two weeks after admission he made several suicidal gestures, and a suicidal attempt, tying a handkerchief tightly round his neck. Clinical and serological examination revealed general paralysis. He received combined fever and penicillin treatment and was discharged recovered in January 1947. When interviewed in 1951 he was free from symptoms. After his discharge he had returned to his wife and resumed his work. His marital adjustment was fair and he was very fond of his son. Here the suicidal attempts were instrumental in securing hospital treatment of which he was in urgent need. Without them he would have received hospital treatment much later, when complete recovery from his illness was no longer possible. Thus they admirably fulfilled their function as timely alarm signals.

Case 4. Mrs. J. J., born 1890, a capable mother and housewife who stood up well to several bereavements during the war when she lost her husband and her favourite son, early in 1946 complained of discomfort in her throat but was told by her doctor that this was purely nervous. She became increasingly depressed and her weight fell from 11 to 6 stone. She thought that she was being watched, became irritable and quarrelsome and after a trivial altercation drank Thawpit, a cleansing fluid, with suicidal intent. She refused to go to hospital and had to be taken to the observation ward without her consent. There she was deeply depressed and agitated, and expressed the conviction that she was suffering from an incurable disease of her throat. As she refused to enter a mental hospital for treatment she was certified, had a short course of electroconvulsive treatment, made a complete recovery within four weeks, and was discharged to resume her life as housewife and boss of a large family. Up to the time of the follow-up, i.e. seven years after her illness, she had remained well.

Here again, the suicidal attempt had acted as an alarm signal and the case also illustrates the discrepancy between the seriousness of the mental

illness, i.e. the depth of the depression, and the relative harmlessness of the suicidal attempt.

Case 5. Mr. H. G., born 1881, married, had been sick for three years before his suicidal attempt, with no prospect of returning to work. He had had a stroke in 1943 : face and articulation were affected and prevented him from resuming work as a porter. He did little but read and sit in the gardens with other old men. Unhappy without his job, and lonely because his wife had to go out to work, he worried over being a burden, often wished that he were dead, and just before the attempt, said several times, ' I shan't be here very long ', thinking that he would soon die naturally. He realized that he was deteriorating physically, felt weaker and complained of pain across his abdomen, but his appetite was good. The climax came when he thought he had had a second stroke. During the evening of 17.6.46 he became more depressed, threatened to gas himself, and tried to cut his throat with a razor. He at once told his wife and his admission to the observation ward was arranged.

On examination he was found to be suffering from congestive heart failure ; there was considerable oedema of his lower legs and some oedema round the sacrum ; he spoke with difficulty owing to the dysponoea. He was at first mentally confused and aphasic, and the left angle of his mouth was down. His heart condition was treated and within two weeks he was quiet, cheerful and sleeping well. He was transferred to a chronic sick ward, and relapsed with cardiac failure, but then made good progress and was discharged home to the care of his own doctor five months after the suicidal attempt.

He gained great confidence from the hospital doctor who had reassured him about his illness, and from having adequate in-patient treatment for his heart failure.

After the attempt, his wife's employer pensioned her, so that she no longer needed to go out to work, and on his discharge six months later she was able to devote the whole of her time to him. He had no further depression and was up and about until the day of his death. Though he suffered much pain he concealed it from his wife. He died in his sleep of a ruptured aneurysm, 4½ months after his discharge from the chronic sick ward.

In this instance, the suicidal attempt was an obvious appeal resulting in a sequence of events all of which aimed at bringing the maximum amount of aid and comfort to a sick man until his death. One of these events implied a far-reaching change in the mode of life of the person closest to him.

The Suicidal Attempt followed by Permanent Institutionalization. With 21 patients (15 men and 6 women) the suicidal attempt was followed by permanent stay in hospital. The attempt appeared to have been the patient's last endeavour at controlling his fate before surrendering to his mental illness. The following cases illustrate this sequence.

Case 6. Mr. K. L., born 1884, had for about two years before his suicidal attempt suffered from a depressive illness without seeking medical help. In May 1946 he tried to drown himself and was rescued by the police. He was found to be suffering from involutional depression with memory impairment, probably due to cerebral arteriosclerosis, and was transferred to a mental hospital where he remained. He had shown no suicidal inclinations

since admission, had settled down to hospital life, and when interviewed in the course of the follow-up, was only mildly depressed, though with marked memory defect. His wife visited him at first but owing to the great distance, and to ill-health (myocarditis) could not continue to do so.

The suicidal attempt marked the patient's inability to live at home any longer, and proved a turning point in his life, ensuring him care and treatment in the only type of environment to which he could adjust.

Case 7. Mr. F. B., born 1902, had for several years before his admission to hospital shown increasing irritability, suspiciousness and lack of inhibition. In 1945 be became openly paranoid and depressed, and at the same time made excessive sexual demands. He was afraid of committing suicide (three members of his family had killed themselves), and threatened his wife and child. When his wife started separation proceedings he became extremely depressed and self-accusatory. One evening he drank acid with suicidal intent and told his wife that he had done so. He was immediately admitted to a general hospital and thence transferred to the observation ward and finally to a mental hospital. His paranoid and depressive symptoms remained stationary and he settled down to a dull retarded state. There was no suicidal attempt in hospital. His wife did not continue with the separation proceedings, but visited him regularly, and said that she would not divorce him as he might try again to take his life. At the time of the follow-up interview, seven years after the suicidal attempt, he was still in hospital.

This is another patient whose suicidal attempt resulted in long overdue hospital treatment. After admission to hospital, the mental illness no longer showed the tumultuous symptoms but a ' schizophrenic surrender ' took place. The suicidal attempt averted the break up of his marriage, although, or possibly because, it marked the end of their living together.

Suicidal Attempt followed by Death soon. In a small group (9 men and 3 women) the suicidal attempt was followed by death from physical illness within several weeks. Here again the attempt appeared to be the last spontaneous act before passive surrender to natural death. Most of those patients seemed to have been aware that they had only a short time to live and wanted to forestall death.

Case 8. Mr. A. A., born 1919, was a chronic epileptic of low intelligence, with aggressive tendencies. During the six months before his suicidal attempt he had been out of work and had neglected himself. He had become increasingly quarrelsome, and in a quarrel was thrown out of the house by his father. He tried to drown himself but was rescued and taken to the observation ward, and from there to a mental hospital, where he remained until his death from toxic myocarditis 4½ years later. In hospital he had been mainly indolent, and had only occasional aggressive outbursts following major epileptic fits. There had been no suicidal attempts.

The suicidal attempt marked the end of his adjustment in the community, both with regard to human relations and to work, life in hospital providing him with conditions to which he was able to adjust.

Case 9. Mr. R. P., born 1880, had been suffering from paralysis agitans for several years. He had been depressed for some time and there had been a general decline of his physical health. In June 1946 he was told by his doctor that he was unlikely to recover from his paralysis. Two weeks later he tried to kill himself by stabbing. In the observation ward he was de-

pressed and greatly concerned about being a burden. He was transferred to a mental hospital where he at first improved under hyoscine treatment, but three months later relapsed into depression. Five months after his admission he collapsed and died from heart failure.

The suicidal attempt was his last act before his final surrender to rapid physical decline.

In all these instances the authorities whose concern it is to come to the aid of the individual in emergency had regarded the suicidal attempt as an indication that these people were, by reason of their mental state, in need of psychiatric treatment.

The Suicidal Attempt as a Recurring Warning Signal. In 8 patients a previous attempt had apparently failed to give the alarm and ensure appropriate action. Only after one or more further attempts were the necessary steps taken.

Invalidism due to Suicidal Attempt and resulting in Change in Human Relations and Mode of Life. In 2 instances in this series the suicidal attempt resulted in lifelong invalidism which transformed the patients' lives. It is impossible to say how much the incapacity and how much the way it came about were responsible for the change in the attitude of the human environment. In the first patient, brain damage had caused a change of personality similar to that after leucotomy. The second patient had become a cripple through the suicidal attempt, losing both legs when he attempted suicide by throwing himself under a train.

Removal from the Scene of Conflict. In 8 patients (4 male, 4 female) the suicidal attempt resulted in only temporary removal from the scene of conflict. These were patients discharged from the observation ward after a few days. This removal proved invariably beneficial, at least for a time. This short stay in the observation ward was not counted as treatment in hospital.

Changes in Human Relations and in Modes of Life. A great variety of changes in the patients' relations to their human environment or in that environment were directly attributable to the suicidal attempt. Changes only indirectly attributable to the suicidal attempt, such as those after successful treatment brought about by the attempt, are not included here. Table 10 (p. 62) shows the most significant, i.e. changes *vis-à-vis* a special person. An improved adjustment in relationship to spouse, parent, etc., was in this group the most frequent single type of change ; in a number of instances it prevented a threatening break. In others the suicidal attempt had the opposite effect, i.e. of hastening and finalizing a threatened break.

In four instances the patient, as the result of the attempt, was either forced into, or voluntarily sought, a state of greater dependence, usually on those on whom he had leaned earlier in life, i.e. a regression to an earlier state of dependence.

14 patients under the impact of the suicidal attempt changed their mode of life or that of members of their families.

The following group illustrates some of the changes referred to in this and in the foregoing paragraphs.

Case 10. Mrs. F. I., born 1910, was unhappily married to a brutal psychopath. They separated in 1944. In 1946 she learnt that he had taken divorce proceedings which, though she wanted a divorce, greatly upset her. She had some time previously started a love affair with a colleague, a married man with one child. Soon after she learnt of her impending divorce, her lover told her that he did not intend to leave his family to live with her, as she had hoped he would. She became acutely depressed and tried to poison herself with aspirin. She was taken to the observation ward whence she was sent to a convalescent ward after two weeks. Three months after the suicidal attempt she resumed work. Her lover left his family after all and at the time of the follow-up six years after her suicidal attempt they were living together and both declared that they were thoroughly happy. She thought that her suicidal attempt ' had brought him to his senses '. Her family, who had been against this relationship, had become reconciled, and finally approved of it.

The suicidal attempt here contributed to the solution of a conflict by not only preventing a break of a controversial relationship but consolidating it and overcoming opposition against it.

Case 11. Mr. B. B., born 1902, made his first suicidal attempt in 1939 by taking an overdose of aspirin two months before his discharge as a long service seaman from the Navy. He had not been a success in the Navy, or gained promotion. The attempt was precipitated by worries over his wife's pregnancy while they could find nowhere to live, and over his lack of a trade. During the preceding depression he had begun to suffer from gastric trouble. As the result of the attempt he was invalided out of the Navy. He had for a long time wanted to leave the service. He did well in civilian life, but soon after his discharge he again complained about gastric symptoms and increasing pain. Five months before his second attempt in 1946 he was admitted to a general hospital for investigation. One of the nursing staff told him he was malingering and he took his own discharge. He could not work or sleep through constant pain and he became increasingly depressed. Three months later he was re-admitted for further investigation. A large gastric ulcer was diagnosed and when he was refused immediate operation he took a large amount of aspirin and opium. He was admitted to hospital in a coma but took his discharge after two weeks. Two days later he made another suicidal attempt by trying to gas himself. At the same time he cut both his wrists and drank opium mixture. He was admitted to the observation ward in a state of deep depression in November 1946. From there he was transferred to a mental hospital. Having recovered from his depression, he had a gastrectomy in February 1947 and was discharged, mentally and physically recovered, a month later. From that time he has kept well. When interviewed in 1953 he said that only after his attempt and admission to the observation ward had he, for the first time in his life, been taken seriously and treated with kindness by doctors and nurses. His wife's attitude to him had changed. Previously irritable and at times ill-tempered, she had become more considerate and affectionate and they had reached ' a perfect understanding '. He had resumed his work as a clerk immediately after his discharge from hospital and had been entirely

contented and efficient. According to his wife, he had become ' a different fellow altogether ' after his discharge from hospital.

This patient made three suicidal attempts, each potentially dangerous. The first secured his discharge from naval service which he had disliked for some time. The second attempt, made in another state of depression, was quickly repeated when he was discharged from hospital without psychiatric treatment. Only after the third attempt did he receive this treatment, which was followed by a successful operation for his physical illness. It is difficult to be sure how much the improvement in his marital relationship was due to his mental and how much to his physical recovery, but the latter alone is unlikely to have resulted in what appeared to be a profound change in the relationship.

Case 12. Robert H., born 1920, while on war work met his future wife, a divorced woman, living with her parents, who wanted a child. Though he was of considerably lower social class, she ' set the pace ' and became pregnant by him. Soon after the resulting marriage she tired of him. He had sunk his gratuity in a house, but when their only child became ill she blamed the illness on the house, and on this excuse, returned to her parents' home, where they rented rooms. Before his suicidal attempt she was refusing to use them with him or to go elsewhere. There were constant quarrels over the child's upbringing, marital relations and social differences. Finally, his food was put in his room and he was told to eat there and stay there. At the time of the attempt his wife was again pregnant and had declared her intention of leaving him. For a fortnight before the attempt he spoke to her of ways of committing suicide but this did not change her attitude. He was discovered making an attempt by hanging, but even this had no effect on anyone in the household and elicited no sympathy or action. After further threats and suicide notes the police were called. In the observation ward he was only mildly depressed, and was discharged after two weeks. He went home but was refused admittance, and his protests were of no avail. After he had tried in vain to find lodgings he returned to his parents, living with them for a time but later taking lodgings near them though remaining a member of their household. He was willing to maintain his children but never paid maintenance for his wife until he had received a prison sentence for refusing payment. He has apparently shown no interest in women since he left his wife.

In this case the suicidal attempt finalized a break which the person who tried to kill himself had tried to prevent. The persons against whom the suicidal attempt was directed, reacted with hatred and counter-aggression, rejecting him completely and finally, and so causing his return to his own family, the first group he had belonged to, i.e. a regression to an earlier dependence.

Case 13. Mr. F. C., born 1902, always hypochondriacal, in 1944 became excessively preoccupied with worry about constipation. He became increasingly depressed and tried to gas himself in May 1946. He was found comatose, and taken to a general hospital. He was transferred to the observation ward and from there to a mental hospital. He recovered after electroconvulsive therapy and was discharged four months after the attempt. His relationship to his wife had improved greatly. Whereas previously there had been a great deal of bickering and quarrelling, she now accepted him as he was—a somewhat inadequate man with ambitions out of his reach. They became more tolerant of each other, and spent much more time together than hitherto ; they used to spend their holidays separately, now they went on holiday together. It was clear from the wife's statement that

his suicidal attempt rather than his depressive illness had made a powerful impact on her and resulted in the change of her attitude towards him. He grew reconciled to his modest professional status and no longer aimed at a leading position, and became an active member of a Church to which his father had belonged.

The suicidal attempt had resulted in long overdue treatment in hospital, leading to an improvement in the patient's relationship to his wife and to a more realistic adjustment to his work ambitions.

Case 14. Mr. R. T., born 1908, was of poor intelligence with a home background of great poverty. His ambition was to have a job like his father's 'with a pension'. He worked for a short time at the gas works where his father was employed but was put off during the depression in 1933. 'This broke his heart.' He had numerous casual jobs in the following years and served in the Forces throughout the war. After his demobilization he rejoined his parents but had many quarrels with his father. He felt that he was unwanted at home and tried to gas himself in 1946. He was discharged from the mental hospital after a month.

At the follow-up six years after his suicidal attempt, he revealed for the first time that he could not write properly. He felt that people laughed at him when this came out in his work, and in the past this had caused him to leave jobs. He did not want to marry because he thought that the same sort of situation would arise. After his suicidal attempt his parents did not want him back. He therefore lodged on his own and led a very solitary life. He said that he felt that he was back just where he was in 1946 (the year of his attempt). He still got very depressed.

In this instance the suicidal attempt resulted in a final disruption of the patient's precarious relationship with his parents.

Case 15. Mrs. A. R., born 1923, had all her life shown gross psychopathy with phobic and schizoid traits. When frustrated she would readily become aggressive and destructive. She had married a casual acquaintance, mainly to get away from home. Her marriage proved a complete failure and they separated after a year. She lived by casual work but did not return home to her parents. In 1944, after an episode of wandering, she was admitted to a mental hospital where she remained for three months, making three suicidal attempts. The diagnosis was hebephrenia. After her discharge she continued going from job to job and leading a very unstable life. During 1944 to 1946 she made four more suicidal attempts, none dangerous. The last attempt, which led to her admission to St. Francis' Observation Ward, marked the end of her efforts to establish herself away from home. She was discharged to the care of her father and remained at home as a psychiatric invalid, expressing vague paranoid ideas and liable to outbursts against her environment. She accepted a position of extreme dependence and made no further suicidal attempts until 1954 when she was re-admitted to a mental hospital after trying to drown herself. After seven months' stay in hospital she was discharged to the care of her mother.

In this case, a suicidal attempt, the last of a series, was followed by a change in the patient's mode of life. She gave up her fight for independence and returned to the dependence of her parental home where she lived a restricted life for eight years, until deterioration of her mental condition disturbed her equilibrium and resulted in another suicidal attempt again leading to hospital treatment.

Case 16. Mr. I. P., born 1914, was below average intelligence, a psychopathic personality and heavy drinker. He had often deserted his wife and children. In 1946 he made his first suicidal attempt after a quarrel with

his wife who was then pregnant and resented his drinking away his Army gratuity. This attempt, resulting in two weeks' stay in hospital, produced a temporary reconciliation and reunion. He soon resumed his unstable mode of life, made another suicidal attempt by cutting his wrist in 1949, and was removed to a mental hospital where he stayed for a month. On his discharge his wife refused to have him back and he lived on his own. Within a year he attacked and robbed an old man and was given a two years' prison sentence. In prison he again attempted suicide. After his discharge from prison in 1953 he could not be traced.

In this case of an antisocial psychopathic personality the first attempt resulted in a temporary improvement of his marital relationship ; the second attempt marked the final disruption of his marriage. Thereupon the patient for the first time committed a crime of violence.

Case 17. Mr. R. R., born 1893, came from a family of which several members had attempted suicide. His work, which involved responsibility for the safety of others, had caused him chronic anxiety and tension for many years. He had even, on occasions, had to return in the night to satisfy himself that he had not made mistakes. For about two months before his suicidal attempt, he had had depressive symptoms which he tried to overcome. In March 1946 he jumped in front of a train, suffered gross soft tissue damage and had to have both legs amputated. He had a period of confusion and was amnesic for the accident. He was admitted to a mental hospital for a year. His personality had changed profoundly : he was euphoric, had greater self-confidence, his libido had increased and he was disinhibited in his relations with others. He declared that he was rejuvenated. His firm put him on light work involving no responsibility, with other disabled men in a quiet friendly atmosphere. His wife had, temporarily, to go out to work, and he enjoyed his increased dependence from his disablement. He had taken up the rôle of a pampered invalid.

The suicidal attempt profoundly changed the patient's and his wife's mode of life, but the possibility that his personality change was due to a brain injury cannot be excluded as it is reminiscent of the frontal lobe syndrome.

Community Aid Roused. In eleven instances the community came to the aid of the person who had made a suicidal attempt, with medical and material help and a rearrangement of mode of life. Sometimes the family group eased the patient's difficulties, sometimes welfare agencies intervened.

Changes in the State of Isolation. 31 patients fell into one of the categories of isolation : they had no fixed abode, or lived in lodgings among strangers or alone in homes of their own, or were mobile by occupation. Table 9 shows the results of the follow-up with special reference to isolation. 6 had remained in hospital and had thus become members of a community. For 9 there was a change in social relations, which for 5 amounted to a change in mode of life. 4 of these 5 made their home with relatives after the suicidal attempt, 1 was given a home by her employer. Of the 25 patients (12 male, 13 female), therefore, who were alive and could be traced, only 10 (5 male, 5 female) did not change their mode of life. For 3 (2 male, 1 female) though the mode of life had not changed, their social contacts

TABLE 9

GROUP I. *Changes in the State of Isolation following the Suicidal Attempt*

	Male	Female	Total
Died within 2 months in hospital . .	4	1	5
Remained in hospital	2	4	6
Mode of life unchanged	5	5	10
,, ,, ,, changed	3	2	5
Unknown (untraced)	4	1	5
	18	13	31

improved. For the others their isolation had either ceased or been modified. For all but one this change had persisted to the time of follow-up.

For some it was not possible to be sure whether the suicidal attempt or the mental illness, or both, had changed the mode of life.

Table 10 shows the social effects of the suicidal attempt found in the follow-up of Group I. In many cases several of these effects could be observed. The figures in brackets refer to those cases in which the suicidal attempt had acted as the only effective alarm

TABLE 10

GROUP I. *Effects of Suicidal Attempts*

(*The figures in brackets refer to those patients who came under psychiatric care for the first time as the result of the suicidal attempt*)

	Male	Female	Total
Temporary stay in hospital and treatment	47(18)	50(29)	97(47)
Permanent stay in hospital	15(4)	6(5)	21(9)
Admission to hospital with death soon after	9(2)	3	12(2)
Invalidism	1	1	2
Temporary removal from scene of conflict	4	4	8
Changes in existing human relations :			
(*a*) apparent improvement	8	19	27
(*b*) separation or break	6	8	14
(*c*) greater dependence	1	3	4
Change in patient's mode of life . .	8	3	11
Change in mode of life of a member of patient's group	1	2	3
Community aid roused	6	5	11
Isolation terminated or modified . .	7	8	15
Effect on suicidal behaviour pattern :			
(*a*) none, i.e. further attempts occurred	4	7	11
(*b*) no further attempts	1	3	4

signal securing recognition and treatment of a psychiatric or physical disorder, or both, which had existed for a considerable time. The patients whose suicidal attempt had fulfilled this function were included in one of the categories of stay in hospital. (There were 8 patients (2 male, 6 female) in this series, and 4 in Group II, where previous suicidal attempts had failed to act as a warning signal.)

The Punitive Reaction of Society to the Suicidal Attempt. A study of the social effects of the suicidal attempt in England would be incomplete without consideration of its possible or real legal repercussions. Persons admitted to a mental observation ward after a suicidal attempt are not as a rule charged with this and, as far as the writers know, against none of the patients of Group I were criminal proceedings taken on the grounds of the suicidal act leading to their admission under the period under survey. However, against 2 patients proceedings had been taken on another occasion ; they were the kind of case in which the law is sometimes applied with severity.

Case 18. Mr. P. A., born 1874, separated, of a working-class family. Little was known of his parents or early environment. His father died at 70, his mother at 60. His brother was thought to have been killed in an air raid. He was described as a poor scholar who could read and write a bit. Up to 1918 he worked in a wood yard and then as a dustman. Subsequently, i.e. for 28 years, he had, on and off, been in receipt of public assistance money. His first wife died aged 32 years, leaving one daughter. He re-married two years later, and by this wife had five children, four of whom were brought up in poor law schools, the fifth in an institution for mental defectives. According to his wife he was cheerful until he fell out of work, when he became depressed and bad-tempered.

His first suicidal attempt occurred at the age of 52, in 1926. He threw himself into the river during an attack of depression and was admitted to St. Francis' Observation Ward. In the same year he jumped off a wall in another suicidal attempt. For this he was charged and bound over. In 1927 he swallowed camphorated oil and was again bound over. In 1929 he jumped into the river again, for this serving a prison sentence of one month. In addition, between 1926 and 1936 he threatened suicide on several occasions and once attempted it by falling out of a second-floor window. During that period he served at least one further sentence for attempted suicide.

In 1936 he was admitted to an observation ward at his own wish because he was depressed and feared he would harm himself. This depression was probably reactive to his wife being in prison for earning while on relief. He was discharged after two weeks. Two months later, in December 1936, he went to the police asking for protection against himself as he feared he would injure himself. He was re-admitted to the observation ward whence he was for the first time transferred to a mental hospital. Within two weeks his depression passed, but he was described as irritable and euphoric. He was discharged a year later, but his wife refused to have him back because during his weekend leaves from hospital he had been quarrelsome and violent. She left him to live with another man. The patient was unable to earn enough to keep himself and entered a workhouse for the first time. From then (February 1938) until February 1946 he was admitted twice to

observation wards and five times to mental hospitals suffering from depressive attacks, the diagnoses being depression with mental deficiency, and manic-depressive psychosis. In 1939 he broke a window in the workhouse after being unable to find work.

Before his last admission he fractured his arm. He was earning his living collecting rags and bones and living in a common lodging-house. Depressed by his incapacity he deliberately broke two shop windows with his shoe, thus invoking police intervention.

Before his attempt in February 1946 he was unemployed and living in one room on his Old Age Pension. He had been depressed for two months after influenza. He was in bed and, on impulse, cut his throat. At St. Francis' Observation Ward he said that he did not know why he had done it. He would like to go back to a mental hospital because he was an old man (70 years) and did not want to face the world. He was re-admitted to a mental hospital as a voluntary patient and remained there for six weeks. He was not found to be depressed but was noted as ' becoming demented '. He took his own discharge but this was his last attempt to maintain an independent existence. Eight months later he was re-admitted to the observation ward on a police order, having attacked his elderly landlady with a shovel. He said he did not know why he did it—' something came into his head '. He said he would like to kill himself as there was no pleasure in life. He was certified. In the mental hospital he was found to have hypertension, cardio-vascular disease and emphysema. The diagnosis was dementia with depression. He quickly recovered from his depression and worked in the ward, though incapable of sustained effort. He remained in hospital, with little change during the subsequent five years, feeble, demented and querulous at times.

At follow-up 4½ years after the attempt he was cheerful but had gross memory impairment for recent and remote events. He admitted his suicidal attempts and laughed about them but could give no coherent account. He had settled happily into his protected environment and showed no wish to leave hospital.

The suicidal attempt was a recurring behaviour pattern resorted to in stress caused by external circumstances or recurrent depressions. Although of inadequate personality and low intelligence he did not make his first suicidal attempt until the age of 52. When admitted in 1946 he already showed signs of dementia which increased with advancing years. Probably his increasing personality disorder, with the tendency to depression and suicidal acts, which started in middle age, had been an early manifestation of the cerebral disease which later led to dementia.

His repeated suicidal attempts ceased only after he had settled down in hospital, but it is not possible to say whether this was due to the change in his mode of life or to the increasing dementia which reduced both his emotions and his initiative.

Case 19. Mrs. S. S., born 1920, had had major epileptic fits since the age of 16. She was of below average intelligence and had a poor work record, changing jobs frequently. In 1941 she was bound over for shoplifting. In 1943 she was admitted to an epileptic colony but left after four weeks, having married a man whom she had known only one day. A week after marriage she lost her job because of her fits and was re-admitted to the colony but her husband took her out again. Soon after he was sent to prison for stealing, and she was again re-admitted to the colony where she was found to be pregnant. Her husband denied being the father of the child. The matron of the colony described the patient as a persistent

mischief-maker and liar. After several months she was sent to a neurological department for treatment and did casual work until 1946 when she threw herself under a van, having been turned out of her lodgings because of her fits and quarrelsomeness. She was admitted to the observation ward, and diagnosed as suffering from an epileptic psychosis. She was certified and transferred to a mental hospital but discharged after eight months. She continued to lead an unstable life, frequently losing jobs and lodgings. In 1949, she made a violent attack on her mother-in-law with whom she had been staying for a short time. She had frequent scenes with her husband, and they accused each other of unfaithfulness. In 1949, after attempting suicide by drinking petrol, she was admitted to a general hospital. Soon after her discharge she made a noisy scene accusing her mother-in-law of trying to poison her. The police arranged her admission to an observation ward where she remained only a few days. After another row she tried to kill herself with barbiturates, was again admitted to an observation ward, certified and transferred to a mental hospital. She left hospital five months later. In 1952 she again tried to poison herself and spent some weeks in a mental hospital. Later that year, after another noisy scene during which she took an overdose of an anticonvulsant, she was removed to prison and charged with attempting suicide. She was put on probation for two years on condition that she became a voluntary patient. Taking her own discharge eleven days later, she was sent to prison for six months for breach of probation. However, two months later she was transferred to a mental hospital as a certified patient. While in prison she had expressed delusions and hallucinations. In hospital she was paranoid and aggressive. When followed-up in 1953 she was reported to have been discharged again. She still had major epileptic fits.

This was a chronic epileptic with severe personality disorder and periods of psychotic behaviour. Like many epileptics, she was very aggressive, and in situations of stress her aggression frequently turned against herself. Her condition did not justify permanent stay in hospital and the law had to be invoked to force her to remain in hospital longer than previously. When she failed to comply a prison sentence of necessity followed. However, before having served it fully, she had to be turned over to medical care.

Chapter 10

GROUP II. 72 ADMISSIONS FOR ATTEMPTED SUICIDE TO THE BETHLEM ROYAL HOSPITAL AND THE MAUDSLEY HOSPITAL FROM 1st JULY 1949 TO 30th JUNE 1950

THE TWO HOSPITALS together (the Joint Hospital) form the postgraduate psychiatric teaching hospital and are associated with the Institute of Psychiatry of the University of London. The number of beds for adults during the above period was 396, 164 male and 232 female. Particular care is taken to have all types of psychiatric condition represented in the Joint Hospital although the proportion of neurotic patients is larger than in other mental hospitals and there is a bias in favour of recoverable conditions. Patients are admitted on a voluntary basis only, some disturbed and unco-operative patients thus being excluded. This limitation does not greatly restrict the selection of patients for this study. Nevertheless, the sample of patients admitted to these hospitals for attempted suicide (Group II) is even less representative of suicidal attempts in the general population than is Group I.

The function of the Joint Hospital has been described, and its patient population analysed, in the Triennial Report (Blacker and Gore, 1955) covering the years 1949–1951. Although the hospital population of 1949 was not specially analysed, there was no reason to assume that it differed materially from those of the two other years surveyed. The Triennial Report, therefore, enabled the present authors to compare Group II with the total population of the Joint Hospital of which they formed a part.

The Composition of the Group. The number of in-patient admissions to the Joint Hospital during the period under survey was 1,150. Of those, 475 (41·3%) were male and 675 (58·7%) female. 72 (6·3%) had been admitted after a suicidal attempt. Of these, 20 were male and 52 female, representing 4·2% and 7·7% respectively of the total for each sex. The proportion of females was therefore substantially higher among the attempted suicide group than in the total hospital population.

Modes of Admission. 39 patients, i.e. 54% (6 male, 33 female) had been transferred from other hospital wards, including 22 from St. Francis' Observation Ward. 7 (4 male, 3 female) had been referred from out-patient departments of general hospitals; and 26 (10 male, 16 female) from the out-patient department of the Joint Hospital and

by consultants who had seen the patients in their homes. These figures could not be compared in detail with the modes of admission among the total hospital population presented in the Triennial Report which were much more detailed. However, the proportion of those transferred from observation wards and general hospitals was much higher among this group than among the total hospital population. On the other hand, a much smaller proportion of Group II had been admitted from the out-patient department of the Joint Hospital than among the total hospital population.

The proportion of admissions to the Joint Hospital precipitated by a suicidal attempt was smaller than among the admissions to the observation wards (6·3% against 10·2%, 10·5% and 11·5% approximately for Groups I, III and IV respectively). This is due to the differences in the functions and modes of admission of the Joint Hospital and the observation wards.

Age-groups. Table 30 (p. 107) shows the representation of the age-groups among Group II. The male patients were too few to allow a meaningful comparison with the total in-patient population of the Joint Hospital. The larger female group showed a representation of age-groups similar to that found among in-patients by Blacker and Gore.

Marital Status. The common Table 29 (p. 106) shows the marital status of the patients in this group on admission. No comparable data were available for the total in-patient population of the Joint Hospital. However, the Triennial Report contains an analysis of the frequency of single (never married) persons in this population compared with that of Greater London. In Group II there were 8 males and 18 females of this status, all in the age-groups between 16 and 44. Their proportion among Group II was higher than among the corresponding age-groups of the total hospital population. However, in view of their small number no conclusions can be drawn from these figures.

Isolation. 11 patients (4 male, 7 female) fell into one of the categories of isolation. Their comparatively small number was probably due to the selection of patients admitted to the Joint Hospital, preference being given to those with relatives or friends willing to take responsibility for the patient should he refuse to stay.

Religion. In this group, also, all religious denominations found in the general population were represented: Church of England 55, Roman Catholics 4, Non-conformists 6, Jews 6, agnostic 1.

Social Class. Blacker and Gore showed that in the Joint Hospital the higher social classes were over-represented as compared with the population of Greater London. This comparison was possible only for males. Table 11 shows the representation of the social classes in Group II which is, of course, too small to allow a valid comparison. At

any rate, this group showed an over-representation of the higher social classes among males. This was also found in the Joint Hospital (Blacker and Gore, 1955). The five classes stipulated by the Registrar General are: I. Professions, etc. II. Intermediate occupations. III. Skilled occupations. IV. Partly skilled occupations. V. Unskilled occupations. The distribution of occupations in Greater London was that established by the last census (Census 1951, H.M. Stationery Office, 1955).

TABLE 11

GROUP II. *Social Class*

(*The figures in brackets are the percentage of the male and female part of the group respectively. JH is the corresponding figure of the Joint Hospital population and L of the population of Greater London*)

	Total No.	Class I	Class II	Class III	Class IV	Class V	No Occ.	Not known
Men .	20	2 (10) JH 9·5 L 4·9	5 (25) JH 9·5 L 4·9	8 (40) JH 49·7 L 54·7	2 (10) JH 11 L 10·7	3 (15) JH 11·8 L 13·1	—	—
Women	52	4 (7·7) JH 6·4	12 (23) JH 15·6	26 (50) JH 63·9	4 (7·7) JH 10·6	3 (5·7) JH 3·5	2	1

Police Intervention. The suicidal attempt was known to the police for 18 patients. Of these, the police had arranged the admission of 16 (4 male, 12 female) into (*a*) general hospitals (14 patients), (*b*) St. Francis' Observation Ward (1 patient), and (*c*) Joint Hospital (1 patient): 10 of those admitted to a general hospital were transferred to the Joint Hospital *via* the observation ward. None was prosecuted. As far as could be seen from the records, the methods chosen by these 18 and the degree of danger to life did not distinguish them from the rest of the series.

Seasonal Fluctuations. The attempts in each of the twelve months under survey were 7, 4, 3, 4, 4, 9, 8, 4, 8, 8, 9, 4 respectively. June and November therefore had the highest numbers.

Diagnoses. Table 33, p. 112, shows the diagnostic divisions. Their percentages have been listed with those in the total population of the Joint Hospital (Blacker and Gore). However, exact comparison with the diagnostic groupings of the Joint Hospital population was not possible as the classification in the Triennial Report was more detailed. To compare 'other depressions' with the groups in the Report, it was necessary to include all categories of neuroses. As senile depressions were in the Report included among manic-depressive reactions, a patient with this condition was included in the percentage of endogenous depressions here. 'Psychopathic reactions' in Group II were compared with the sum of the percentages of the categories of patho-

logical and immature personality and addictions listed in the Triennial Report. The latter had a category of unspecified miscellaneous conditions which amounted to 9·8% of the total. The comparison, as far as it goes, shows that depressive conditions and psychopathic reactions were over-represented among the attempted suicide group, as was to be expected, whereas the proportion of schizophrenics among the group did not exceed expectation.

Only one patient, a female, was an epileptic; she was included with the psychopathic reactions. 3 patients, all female, were mental defectives who attempted suicide in a state of reactive depression; 2 men were alcohol addicts and 2 women were suffering from chronic alcoholism. 3 more patients had taken alcohol immediately before the suicidal attempt.

Broken Homes. Loss or absence of one or both parents by death or desertion below the age of 16 was established for 23 of the 72 patients. For 6 of them the loss had occurred before the age of 6, and for 6 between the ages of 6–10 years. Of the 21 who had lost parents, only 2 (both male) had lost both parents before the age of 16 years.

Gross parental discord, present or reported, was found to have existed for 21 (6 male, 15 female) of the remaining 49. Among the rest, it appeared to have been absent with 15 (3 male, 12 female), probably present with 4 (1 male, 3 female), and for 9 patients (4 male, 5 female) it was not possible to establish the relevant facts.

The significance of these figures cannot be evaluated in the absence of suitable control groups.

Suicide in Patient's Family. With 4, probably with 5 patients (1 male, 3, probably 4, female) a parent or sibling had died from suicide. With 4 more (2 male, 2 female) other relatives had killed themselves.

Previous Suicidal Attempts. 24 patients, 8 male and 16 female, had made previous suicidal attempts. Of these, with 11 (2 male, 9 female) the attempt had been a recurrent behaviour pattern in emotional stress. The number of attempts made by those 11 patients, including subsequent attempts, was 32 (6 male, 26 female). Of those attempts, 15 had not resulted in admission to hospital.

The Social Constellation in the Situation of the Suicidal Attempt. It is striking that many attempts are carried out with other people near by, and that the patient's closeness to others does not seem related to the seriousness of the attempt. In this group and in Group IV special attention has been paid to the patient's nearness to others during the suicidal act, as far as this could be done retrospectively. As the case notes were much fuller than those available in Group I, these particulars were available for all but 10 patients of Group II.

The Site of the Suicidal Attempt in Relation to the Social Field. The suicidal attempts have been grouped according to the person's proximity to others at the time of the attempt. This is shown in Table 12

for this and other groups for which relevant information was available. The suicide series has been included in this table for comparison. A large majority of the patients in Group II were near others while committing the suicidal act. In this series, a higher proportion of men than women were alone at the time of the attempt, and both the patients who tried to take their lives in an unfrequented public place were male.

TABLE 12

GROUPS II, III, V *and* S. *Sites of the Suicidal Acts in Relation to the Social Field*

	Men				Women			
Group	II	III	V	S	II	III	V	S
No. of patients	20	66	26	73	51	101	50	44
Much frequented public place	—	15	2	5	3	16	4	1
Little frequented public place	2	3	—	5	—	4	—	2
Others present in house or flat	8	18	10	16	28	36	19	7
Others in same room	1	9	4	2	1	7	4	2
Alone in house, flat or work place	7	14	6	44	12	30	19	32
Unknown	2	7	4	1	8	8	4	—

No marked difference was found in the methods used by those who were alone during the suicidal attempt as compared with those used by the group as a whole; the order of frequency of the methods remained the same. In view of the period since the suicidal attempt it did not seem possible to grade these patients for seriousness of the attempt nor to compare those who had been alone at the time of the suicidal act with the rest of the group from this point of view.

The Persons Near at Hand during the Attempt. Table 13 shows for the Groups II, III, V and S the kind of person, if any, near to the patient at the time of the attempt. 'Special persons' were members of a group to which the patients belonged—e.g. relatives, neighbours, employers or colleagues, with a special relationship to the patient. 'Others' were such as to be expected in public places where the attempt was made. In 43 of the 52 'known' instances (72%) in Group II the patient was not alone.

Agent Intervening in the Suicidal Act. Often the suicidal act was interrupted or its effects counteracted either by the patient himself or by others. This is shown in Table 14 for the Groups II, III and V. In 37 among the 55 instances of Group II for which full information

TABLE 13

GROUPS II, III, V *and* S. *Degree of Isolation during the Suicidal Act*

	Men				Women			
Group	II	III	V	S	II	III	V	S
No. of Patients	20	66	26	73	52	101	50	44
Special person near	2	11	8	16	14	16	7	5
,, ,, in company	1	5	3	—	—	4	4	—
,, ,, no relevant data	—	2	—	—	—	2	—	—
Others near	7	20	5	26	20	32	19	8
,, in company	—	6	1	—	—	4	1	—
,, no relevant data	—	—	2	—	—	4	—	—
Alone	8	14	6	30	9	30	16	31
Unknown	2	8	1	1	9	9	3	—

was available, the persons intervening appeared accidentally but their appearance was to be expected in the circumstances in which the suicidal attempt was made. The neighbour calling unexpectedly, sometimes attracted by the smell of gas, the husband coming home earlier, the passer-by preventing the patient from throwing himself over the parapet of a bridge; these were accidents to be expected in a proportion of cases, and against their possibility no safeguards had been taken by the patients in this and other groups of suicidal attempt. In this, the social constellation of suicide differs greatly from that of attempted suicide. Only in one instance had the person who intervened been expected by the patient to appear at the time of the suicidal attempt.

TABLE 14

GROUPS II, III *and* V. *Agents Intervening*

	Men			Women		
Group	II	III	V	II	III	V
No. of Patients	20	66	26	52	101	50
Patient	5	19	9	12	24	16
Special person (expected)	—	6	4	1	9	4
,, ,, (accidentally)	3	9	7	9	6	6
,, ,, (no relevant information)	1	—	1	3	5	2
,, ,, (present)	—	—	2	—	—	1
Others (expected)	—	—	—	—	3	—
,, (accidentally)	7	18	3	18	35	16
,, (no relevant information)	2	6	—	2	4	2
,, (present)	—	—	—	—	—	—
Unknown	2	8	—	7	15	5

Movement during the Suicidal Attempt. Sometimes the person committing the suicidal act moves towards people in the course of the act while the self-injury is taking effect. This is usually prompted by the impulse to counteract danger to life. Under this heading any kind of action aimed at getting into touch with others and mobilizing help has been included. The patient may tell his spouse or relatives, may go to the police, use the telephone, etc. Here again, the methods of self-injury employed by those who fall into this category did not differ from those used by the group as a whole. In this series with 63 cases in which information was available, 16 patients (5 men and 11 women), i.e. 25·4%, moved towards people during or immediately after the suicidal act.

Methods. Table 32 (p. 110) shows that in this group narcotics, aspirin and other poisons were used relatively more frequently than in Group I whereas the incidence of wounding and jumping from heights was lower. Fewer men used coal gas than in Group I. There was no difference between those who were alone and those who were near others in the situation of the suicidal act.

Results of the Follow-up Investigation

The larger part of this investigation was completed in 1953 and 1954; the period covered by the survey is therefore four to five years.

Disposal. 67 patients (18 male, 49 female) left the hospital, 5 of them (3 male, 2 female) against advice. 5 patients (2 male, 3 female) were transferred to a mental hospital directly or *via* an observation ward.

It is noteworthy that only 26 of the whole were after admission to the Joint Hospital placed under special observation.

Time Elapsing between Suicidal Attempt and Discharge. 24 patients were discharged, recovered or relieved, within less than three months, 33 within three to six months, 13 within six months to one year and 2 after more than one year. None died in hospital.

Table 15 shows the state of the group on completion of the follow-up.

Table 15

Group II. *State of the Group at Closing of Follow-up*

	Men	Women	Total
Died within 5 years (including 2 suicides)	3	4	7
In mental hospital following re-admission	—	4	4
Out of hospital	17	43	60
Untraced	—	1	1
	20	52	72

7 patients (3 male, 4 female) had died in the interim. 2, both male, were over 60; one died, aged 80, from old age, one year and nine months after the attempt, and the other from pneumonia at the age of 66. Two women, aged 47 and 63, died from Hodgkin's disease and cerebral haemorrhage respectively. Both had at the time of the attempt been ill with the condition from which they died. The fact that only 10% of this group had died by the time of the follow-up, as against 18% in Group I, was probably due to selection as well as to the shorter period surveyed.

Two patients, a male of 45 and a female of 41, committed suicide. These two will be discussed below.

Total Re-admissions to Mental Hospitals. 22 patients had been re-admitted to mental hospitals on 33 occasions during the period under survey, but only 4, all women, were found in mental hospitals at the time of the follow-up. Those in a mental hospital at the time of the follow-up were suffering from depressive psychosis or schizophrenia. None had remained in hospital since the suicidal attempt. This is another illustration of the fact that the population of the Joint Hospital was biased in favour of patients with a better prognosis.

Subsequent Suicidal Attempts. 1 man and 10 women made subsequent suicidal attempts. The two suicides are not included among these. Invariably, the repetition of the attempt was due either to a recurrence of the situation leading to the previous attempt or to similar stress.

Subsequent Suicides. Two patients committed suicide within the period under survey.

Case 20. Mrs. M. M., born 1911. *Obsessional neurosis with recurrent depression, suicidal attempts and suicide.* The patient was the fifth of ten children. She was an over-anxious child, terrified of her drunken father. From the age of 14 she was preoccupied with a counting compulsion which, however, did not interfere with her work in factory and household. She married at the age of 25, and had three children whose upbringing caused her much concern. Her counting compulsion grew increasingly to interfere with her efficiency as a housewife and mother. She would keep the children in a bath for hours, unable to take them out until she had finished her number ruminations. Her condition was discovered when she took one of the children to a psychiatrist. In view of the longstanding nature of the neurosis she was advised to undergo a prefrontal leucotomy which was performed in 1947. This greatly relieved her compulsion for a time but she developed periods of severe depression lasting for two to three months. In one of these she made her first suicidal attempt; she put her head in the gas oven but withdrew it after a few minutes. Two weeks later she took a large number of aspirin tablets and was admitted in a confused state to St. Francis' Observation Ward whence she was transferred to the Maudsley Hospital. The depression subsided completely within six weeks. She attended the out-patient clinic and remained well for eleven months. She relapsed in July 1951 and again tried to gas herself. Again she herself intervened and was re-admitted to hospital. She was aware of strong

suicidal impulses which she fought against. She recovered without special treatment after her depression had lasted for four months. Eight months later she again relapsed and expressed suicidal impulses. When advised to enter hospital immediately she was reluctant and remarked that she had had suicidal intentions before and that her previous suicidal attempts had always been of such a nature that she had been saved. The same would happen again if she repeated the attempt. She persuaded her doctor and her husband not to have her removed to an observation ward as they had been advised by the psychiatrist.

On 16.6.1952 she was admitted to a general hospital having swallowed the contents of a large bottle of aspirin, and been discovered in a coma the next morning. She failed to respond to treatment and died on the same day.

The suicide was in this case due to the failure of those responsible for her safety to protect her against her self-destructive impulses. This patient's chances of surviving her last suicidal act were not inconsiderable : she had given due warning and had chosen a drug whose high toxicity is not well known to lay persons. Something went wrong in her environment and what might have been a typical suicidal attempt, turned into suicide. In this and similar instances one could speak of a ' bungled suicidal attempt '.

It may be argued that she would have killed herself sooner or later. This is far from certain : on previous occasions, once in hospital she did not persist in suicidal acts and as she had given due warning on each occasion she might have survived, like other patients, many periods of depression, and possibly the suicidal impulses would have subsided later in life.

Case 21. George S. R., born 1904, *psychopathic personality. Suicidal attempt and subsequent suicide.* The patient was the youngest of 4 children. His father deserted the family when he was 10 days old. His mother cared little for him and he was adopted by an uncle and aunt. When in hospital he sometimes referred to the lack of mother-love in his childhood. He entered the Merchant Navy and reached the rank of Master. Forced marriage at the age of 27. They separated in 1948. Soon afterwards he was admitted to the Maudsley Hospital suffering from depression and alcohol addiction. He left against medical advice after a month. He continued to drink heavily, got into financial difficulties, and had to sell a florist's shop he had bought with borrowed money. He started an affair with his previous shop assistant, a married women, Mrs. M., and persuaded her to leave her husband. She lived with him for a short time, and was the only woman with whom he had ever been fully potent. When she left him under pressure from her husband, the patient was severely depressed and took a large dose of sodium amytal. He was found by his landlady with whom he had had a friendship before he met Mrs. M. He was admitted to the Maudsley Hospital in November 1949, but refused to co-operate, resented the hospital discipline and again left against advice, having been in hospital only five weeks. After his discharge, Mrs. M., apparently moved by his suicidal attempt, returned to him. He alternately lodged with her and his previous landlady. He drank heavily, especially when he became involved in Mrs. M.'s divorce proceedings. She finally left him. In October 1950 he was re-admitted after a fall while drunk, but left hospital after three weeks, having been so unco-operative that it was decided that he should not again be re-admitted. He went into lodgings for two months. He was then offered a job as a buyer by his previous landlady, who owned the flower-shop which once belonged to him. She kept a motherly interest in him. He accepted her offer to take a room in her house and he seemed contented, but often depressed. In such moods he would sometimes remark

that one day he would end his life. When she returned from a two days' holiday the patient was missing. He was found dead in the shop, having taken an overdose of sodium amytal. On the day of the attempt he had learnt that Mrs. M. had re-married.

This patient had lifelong difficulties in his human relations, which were probably due to his unhappy childhood. He rejected help offered by the hospital. Both his suicidal attempts and his suicide were reactions to being deserted by a married woman with whom he had been in love. This experience probably revived the loss of his mother to which he had often attributed his difficulties in forming relations with others. The suicidal attempt temporarily restored to him the object of his love. When he finally lost her he took his life. This man's difficulties in forming relations were associated with his intolerance of frustration. This combination, so frequent in psychopaths, made him incapable of accepting psychiatric help.

Sequelae and Effects of Suicidal Attempts. The same types of immediate and remote sequelae and effects of the suicidal attempt were found as in Group I. Most of the patients had formed a personal relationship to the hospital where they had spent some time, usually at least three months. They almost without exception co-operated in the follow-up investigation. All, except one, could be traced. Table 16 (p. 76) demonstrates the various effects of the suicidal attempts. It is proposed to present extracts of some cases of special interest to supplement the observations in Group I.

With all but 3 patients the suicidal attempt resulted in temporary treatment in hospital. Only with one patient was the suicidal attempt followed by permanent stay in hospital. With two patients the stay in hospital was short and effected only temporary removal from the scene of conflict.

In almost two-thirds the suicidal attempt had caused the patient to receive psychiatric or other medical help which had been overdue but which the patient, for various reasons, had failed to receive. The majority of the cases reported below illustrate this important function as well as other effects of the suicidal attempt.

The psychological impact of the suicidal attempt on the patient's environment could be studied more closely in this group than in Group I because more information was available. Mourning reactions similar to that referred to in cases 27 and 28 (p. 79) were frequent: as depression and guilt on the part of the relations most closely affected and endeavours to make reparation. The reactions of the community were similar.

Changes in the State of Isolation. 11 patients (4 male, 7 female) had before the suicidal attempt lived in isolation. At the follow-up the mode of life had remained unchanged for 6 (3 male, 3 female) but there had been an improvement in contacts for 4 of them (2 male, 2 female). For 5 (1 male, 4 female) it had so changed that they no longer lived in isolation.

TABLE 16

GROUP II. *The Social Effects of Suicidal Attempts*
(The figures in brackets refer to those patients who came under psychiatric care for the first time as the result of the suicidal attempt)

	Men	Women	Total
Temporary stay in hospital and treatment	19(12)	51(30)	69(42)
Permanent stay in hospital	—	1(1)	1(1)
Invalidism	—	2	2
Temporary removal from scene of conflict	1	1	2
Changes in existing human relations :			
(*a*) apparent improvement in relation to a special person	4	13	17
(*b*) separation or break	4	5	9
(*c*) greater dependence	2	3	5
Change in patient's mode of life	2	4	6
Change in mode of life of a member of patient's group	—	2	2
Community aid roused	3	2	5
Isolation terminated or modified	3	6	9
Effect on suicidal behaviour pattern :			
(*a*) none, i.e. further attempts occurred	—	2	2
(*b*) no further attempts	2	8	10

Table 16 shows the social effects found in this follow-up. Compared with Table 10 (p. 62) it illustrates the bias towards conditions with a good prognosis in the selection of patients admitted to the Joint Hospital.

Case 22. Mrs. A. Y., born 1910, had been intermittently depressed for nearly five years since the loss of a premature baby, for which she blamed the hospital. She relapsed again on learning that a neighbour was pregnant. She tried to kill herself and her only child by barbiturates and coal gas. In hospital she presented severe depressive symptoms with marked hysterical features. Matrimonial difficulties concerned with her husband's suspected unfaithfulness played a part in the etiology of her illness. Her husband, for professional reasons, was away from home a great deal, and the patient had been living with two elder sisters, one of whom was an aggressive psychopath who dominated her. She saw her husband only at weekends. She had been unable to make up her mind to join him, had been living in a constant conflict of loyalties, and had remained dependent on her family. On discharge from hospital she decided to leave her sisters and set up home at her husband's place of work away from her family. He had become more tolerant of her, and their relationship showed a distinct improvement in that they made mutual concessions. Five years after her suicidal attempt new difficulties arose, but no further suicidal attempt had occurred.

The suicidal attempt brought about the patient's admission to hospital and treatment after she had suffered from severe depression for a very considerable period. Her over-dependence on her family ceased and was replaced by a more mature relationship. Her relationship to her husband improved. Even more so than before the attempt, she concentrated her

affection, a possessive over-anxiety, on her child, who reciprocated by acting as her defender against the father.

Case 23. Edward W., born 1924, first showed signs of mental disorder a year before admission to hospital. At times he wandered about aimlessly and gave evidence of magic thinking. However, he carried on with his work most of the time, although becoming increasingly unstable emotionally and at times talking unintelligibly. His parents, though gravely concerned about his behaviour, were anxious to deny the existence of mental illness. In February he made what seemed to be a half-hearted suicidal attempt by scratching his neck with a razor blade and trying to climb out of the window. Soon afterwards he put his head into the gas oven and tried to mutilate his penis. At that time he was seen in catatonic postures. His parents still hoped that he would recover without hospital treatment but he had to be looked after by a nurse. In March he threw himself through a window and was unconscious for an hour. He was admitted to hospital in April 1950, diagnosed as a catatonic schizophrenic and treated with insulin and electro-convulsive therapy. There were no suicidal attempts while he was in hospital. He made a good recovery and left hospital free from symptoms in December 1950. He was interviewed in 1953. He had done well professionally and his relationship to his parents was better than it had been for many years. Formerly a non-mixer, he had become more sociable.

This case shows a crescendo of suicidal acts forcing reluctant relatives to take the only appropriate action, i.e. admission to hospital. In not heeding the warnings of the earlier suicidal attempts the relatives had gravely endangered the patient's life, as every further suicidal attempt was associated with an increasing risk.

Case 24. Mrs. R. I., born 1895, was at the age of 22 forced into an arranged marriage by her mother, to a man below her socially. However, she was glad to get away from an unhappy and turbulent home. Ten years later she had her first attack of depression during which she made a suicidal attempt. She made another a year later and was admitted to a mental hospital where she stayed for seven months. She remained well until 1948 but suffered a great deal of marital unhappiness. She had been severely depressed for several months when in 1948 she tried to poison herself with aspirin. Immediately after taking the aspirin she screamed (i.e. a shouted appeal for aid). She was admitted to the Maudsley Hospital where she was treated by psychotherapy. She was discharged after four months. During that time she broke with her husband, who during the period of depression preceding the suicidal attempt had repeatedly threatened her with certification. She never returned to him. Her children sided with her against the father, and provided a home for her. Since then she has been living with one of them. She had a period of depression in 1952 without making a suicidal attempt. When seen in 1953 she expressed no regret for having left her husband but would probably not have done so had not her children been ready to take care of her.

The suicidal attempt had a variety of effects; it led to her admission to hospital and long overdue treatment; it resulted in a rupture of her marriage and a new mode of life for her and her husband. Probably she had for some time been wishing to leave her husband, and the suicidal attempt facilitated the break. This is an instance where the aggressive character of the suicidal act was obvious.

Case 25. Joseph B., born 1882, resigned from his work as a clerk (two years before his suicidal attempt) at the age of 67, because he believed that his memory was impaired and that he would therefore make serious mistakes

and be discharged. He missed his work greatly and found it extremely difficult to adjust to retirement. In September 1949 he took a large overdose of sleeping tablets. He was found unconscious and taken to hospital. The diagnosis was involutional depression with paranoid features. He was in hospital for six months. He recovered after electroconvulsive therapy and re-educational psychotherapy which laid special emphasis on his socialization. He was offered community aid by being placed on the Disabled Persons Register and being offered a new job, but did not take this up. When he returned home he had reconciled himself to his retirement, and joined an Old Age Pensioners' Club, of which he became an active and popular member. His relationship to his wife, who was some years older than himself and in poor health, had greatly improved.

The suicidal attempt started a course of events resulting in long overdue treatment, recovery and a complete reorientation of his life. He successfully adjusted himself to a situation which before the suicidal attempt he had refused to accept. The community had come to his aid with its material, social and spiritual resources.

Case 26. Mrs. C. A., born 1904, an over-anxious woman, had been subjected to prolonged strain by her child's illness. She was much alone, especially at night, when her husband was on night shifts. In June 1949 she became depressed and by August 1950 had compulsive thoughts of murdering her child. Only in September 1950 was she sent to a psychiatric clinic which she attended for two months, before being advised to seek in-patient treatment at the Maudsley Hospital. There was a fortnight's waiting period before she could be seen. Three days before the appointment she thought for the first time of killing herself. When she was seen by the psychiatrist she concealed this fact and appeared only slightly depressed which made the psychiatrist doubt the need for admission. On the following day she returned to the out-patient department as recommended, for an injection. The next day she made a serious attempt with gas and barbiturates. She was admitted to the Maudsley Hospital where she was treated for three months. She was discharged recovered after psychotherapy and electroconvulsive treatment. Four years later she was free from depression but had a paranoid attitude to her neighbour. While she had been in hospital her husband, who felt very guilty about having left her alone so much, had given up his work of which he was very fond and in which he had been engaged for 20 years, and had taken an entirely different job with regular hours and without night work. His income had become smaller but the change allowed him to see more of his wife. Their relationship had improved considerably as they were more together and the patient no longer felt neglected.

In this case the suicidal attempt had resulted in immediate hospital treatment not deemed necessary by the psychiatrist at the time. (Immediate admission would probably have prevented the suicidal act.) She was treated successfully and the suicidal attempt resulted in far-reaching changes in her and her husband's mode of life: he changed his work and their relationship improved considerably.

Case 27. Mrs. S. D., born 1900, was suffering from recurrent depressions which lasted up to a year. She was married to an inadequate, jealous and ill-tempered man, who badly needed her support. Until her suicidal attempt she had never been in hospital during her depressions. In 1949 she became profoundly depressed. She feared she was becoming insane, and felt that people talked about her. Six months after the onset of her depression, she disclosed suicidal impulses to the psychiatrist but hid them

from her husband. Out-patient electroconvulsive therapy was arranged, but nine days before the first appointment she was found unconscious, having tried to gas herself. She was admitted to hospital but the depression had cleared and she was discharged after five weeks. When interviewed four years later she said that her suicidal attempt has been a tremendous shock to her husband whose behaviour towards her had since greatly changed. He had become much more considerate and only rarely lost his temper. Her previous periods of depression had made very little impression on him. It was the suicidal attempt that shook him deeply. The patient had also been deeply impressed by the doctors' endeavours to understand her personal difficulties. As she had never received hospital treatment when depressed, this had been a new experience to her which she called a miracle. She had kept well until two months before the follow-up interview when she became depressed again but she had no suicidal intentions.

In this case the suicidal attempt, which caused a period of unconsciousness, resulted in a disappearance of the depressive symptoms, acting like successful shock treatment. It led to her first admission to hospital and brought about a considerable improvement in the husband's attitude to her. The previous depressive illnesses had failed to make a similar impact on him.

Case 28. Mr. T. P., born 1903, was inadequate, quarrelsome, with a poor work record. Several times he had left his family and stayed away for weeks. He was jealous of his wife and hated his son for taking some of her affection from him. In 1948, in a state of anger, he made an abortive attempt to gas himself. He was depressed during the last quarter of 1949, there had been frequent quarrels, and his wife had threatened to leave him. In December, after a row, he took a large dose of aspirin and declared that he wanted to take his life. His wife ignored the threat. The next day he again took a large dose of aspirin with suicidal intent. On this occasion the doctor was called and his admission to hospital arranged. He remained there for two months and was given psychotherapy. $3\frac{1}{2}$ years later it was found that he had undergone a remarkable change. Previously changing jobs frequently and often out of work, he had been a steady worker since his discharge from hospital. His relationship to his wife had greatly improved. He was considerate and rarely quarrelled. His relationship to his son had become normal and there was no undue jealousy. The patient attributed the change in his outlook to the treatment he had received in hospital. He had been deeply impressed by his wife's and son's reactions. He even declared that he was glad of the attempt because it made him realize what his wife and son meant to him and thus had made a different man of him. Whereas previously he had often left home, he now never left his wife and wanted to be with her as much as possible. His wife's and son's attitude towards him had also changed: both had become more affectionate and more tolerant.

The suicidal attempt led to admission to hospital and successful treatment. It is noteworthy that the attempt leading to his admission had been preceded by one which had been ignored. That attempt had failed to act as an alarm signal. The next set in motion a series of actions which profoundly changed the patient's outlook. His relationship to his wife improved and the threat of separation was averted; his morbid jealousy towards his son had subsided. These changes were accompanied by corresponding changes on the part of his family whose reactions to his last suicidal attempt had much in common with mourning.

Case 29. Mrs. R. A., born 1900, had an unhappy married life: her husband left her from time to time to live with another woman. He used

to return full of guilt and good intentions. In July 1949 he once again returned home and emphatically declared that he had come to stay. A few months later he became restive again, and asked her to divorce him. She took the contents of a large bottle of aspirins, rang up her husband to tell him that she could not go on, and set out to see him at his place of work. Halfway there she left the bus and walked the streets waiting for the aspirin to take effect. However, after two hours, she told a policeman and was taken to a general hospital whence, after a gastric lavage, she was transferred *via* the observation ward to Bethlem Royal Hospital. While her discharge was under discussion a psychotherapeutic interview resulted in a very strong abreaction, releasing her previously repressed hostility against her husband. She left against advice, three weeks after the suicidal attempt. She remained depressed and preoccupied with her ' racing heart ' for several months. She was temporarily dependent on her elder son for about five weeks. When she again took charge of the household she had the support of her three sons who had taken her side throughout the marital disputes. While in hospital she was advised by the psychiatrist to write to her husband that she wanted a complete break and that she did not wish to receive his visits nor his letters. At the follow-up interview four years after the suicidal attempt, she appeared very well. She had given her consent to divorce several months previously. Since she had left hospital she had established herself as a civil servant and made a position for herself which gave her self-respect, security and the respect of her sons. She regarded the suicidal attempt and the subsequent short stay in hospital as a turning point in her life which had ' cleared her system ' of a long-standing conflict.

In this case the suicidal attempt completed the break in an unsatisfactory relationship and thus brought about a satisfactory solution.

Case 30. Miss S. Y., born 1912, came from a family in which suicide had played a considerable part. Her father and his father had committed suicide. Her mother had often threatened suicide. Father's sister had attempted suicide. A strong antipathy developed between the patient and her mother which persisted throughout the patient's life. The patient had had mild neurotic symptoms while growing up. After several years of unsatisfying work, at 20 years her adolescent daydreams crumbled, and as a reaction to a strong feeling of restriction by her mother she made her first suicidal attempt by trying to poison herself with her mother's sedatives. In consequence she left home and took up secretarial work. However, she continued to be restless and discontented and lacking a satisfactory love relationship. While staying with friends in 1948 she made her second suicidal attempt, again by poisoning. She was admitted to a mental hospital where she stayed for several months. As the result of this suicidal attempt she lost her job. She made her third attempt in 1949 on the sudden threat of having again to live with her mother who had been treated in a nursing home for a depression. The patient explained that she wanted to kill herself in order to escape from her mother and from her impulses to kill her. She was hospitalized for three months and received intensive psychotherapy. During that period her mother died. The patient decided to restart her work as a secretary. Soon after her discharge from hospital she met a man with whom she established a satisfactory love relationship and since then she has not considered suicide.

In this case, family suicides are likely to have contributed to the patient's proneness to suicidal acts. Each of her three attempts was followed by marked changes in her mode of life. After the third attempt the pattern of suicidal behaviour did not recur. This can be attributed not only to

the treatment she received but also to her mother's death which, in turn, might have enabled her to form a normal love relationship for the first time in her life.

Case 31. Mr. F. E., born 1880, a widower, had worked in a factory for 48 years until forced to give up work owing to heart and bronchial trouble. He greatly missed his work and his mates. During the winter of 1949 he became short of breath and increasingly depressed and anxious. When his sister with whom he lived ordered him to bed he attempted to poison himself with aspirin. After emergency treatment in a casualty department he was admitted to the Joint Hospital where he remained for three months. He showed a special ability in rug-making which he continued after his discharge home. His physical condition had greatly improved as the result of treatment. For several months after his discharge he attended the out-patient department for supportive psychotherapy. On the advice of the psychiatrist he joined a club for old people and fully adjusted himself to his retirement and the limitations imposed upon him by his physical disability.

In this aged man the suicidal attempt resulted in physical and psychological treatment which enabled him to adjust to his life situation successfully.

Chapter 11

Group III. 167 Admissions for Attempted Suicide to St. Francis' Hospital Observation Ward from 1st January 1953 to 31st December 1953

A number of aspects of attempted suicide cannot be satisfactorily studied months or years after the event. Some have been investigated in this series, all of whom were interviewed by one of the present authors (E. S.) shortly after their admission.

Composition of the Group. During 1953 the total admission rate to the observation ward was 1,587 (693 male, 894 female). 167 (10·5%) (66 (9·2%) male, 101 (14·1%) female) were admitted after suicidal attempts. Owing to shortage of staff, 18 out of 41 beds in the male section were closed from October 1953 to January 1954, and this must have been partly responsible for the large difference between male and female admissions, but even so there would probably have been a majority of females. 60 of this series (22 male, 38 female) had been admitted to mental hospitals previously on 111 occasions (39 male, 72 female).

Age Distribution. This is shown in Table 30 (p. 107). 22 patients (8 male, 14 female) were over the age of 60.

The age-groups in this series were related to the age-groups found in all patients discharged from this observation ward during 1953. (In this ward all patients were routinely allocated to age-groups on discharge, whereas in this study the allocation was made on admission. In comparing, therefore, Group III with all patients discharged, a certain inaccuracy was bound to arise, but it was so small that it can be neglected. The total number of admissions in 1953 differed from that of the discharges only by 5 for each sex.) The age-groups containing most patients were the same for both sexes. This held true when the number of those admitted for suicidal attempts was deducted from the rest of the admissions. The peak of the totals of both sexes together fell in the same age-group as that among females, which was to be expected in a series with a marked female majority.

It would be a matter of some interest if the relative equality of the representation of the different age-groups among attempted suicides admitted to psychiatric hospitals and that among the total population of those hospitals could be generally confirmed. It may mean that the ages of susceptibility to mental illness and liability to suicidal acts coincide.

TABLE 17

GROUP III. *Age Distribution*

(The figures in brackets represent the numbers of all patients discharged from this observation ward)

	Men	All Discharged	Women	All Discharged	Total	Total Discharged
10–14	—	(1)	—	—	—	(1)
15–24	7	(90)	12	(75)	19	(165)
25–34	19	(155)	24	(159)	43	(314)
35–44	16	(137)	25	(187)	41	(324)
45–54	10	(121)	18	(156)	28	(277)
55–64	9	(89)	10	(116)	19	(205)
65–74	4	(66)	7	(105)	11	(171)
75–	1	(39)	5	(91)	6	(130)
	66	(698)	101	(889)	167	(1587)

Marital Status. This is shown in Table 29 (p. 106). 57·5% of the men and 50·5% of the women at the time of the suicidal attempt were either single, widowed, divorced or separated.

Isolation. The proportions of those in one of the categories of isolation (no fixed abode, mobile through occupation, living alone, living in ordinary lodging, hostel or hospital) was even higher than in Group I. It comprised 21 (31·8%) men and 27 (26·7%) women. The corresponding percentages among Group S (suicides) were 8% higher for men and 19% higher for women.

Religion. Church of England 117, Roman Catholics 21, Non-conformists 12, Jewish 3, others 2, unknown 12.

Social Class. This was assessed for men only (Table 31, p. 108). Classes I, II and III were under-represented, as compared with the available figures for Greater London.

Diagnoses. These are shown in Table 33 (p. 112). Alcohol was known to have played a part in the suicidal act in 11 (18·4%) of the men and in 8 (7·9%) of the women, and probably did so in 3 more (male) : but only 4 patients, all male, were classified as alcohol addicts. There was no case of chronic alcoholism. 5 men and 6 women were epileptics.

Seasonal Fluctuations. The following was the monthly distribution of the cases : Men 8, 5, 3, 10, 6, 9, 5, 5, 3, 3, 6, 3. Women 8, 7, 5, 7, 14, 12, 10, 5, 9, 10, 9, 5. In both sexes the incidence was highest in the second quarter of the year.

Methods. Table 32 (p. 110) shows the methods employed. The most striking difference between this group and Group I was the much higher incidence of drugs, especially narcotics, in Group III, obviously

at the expense of hanging, wounding, gassing, corrosives or jumping from heights. The probable cause of this change has already been referred to (p. 30).

Modes of Admission. Table 27 (p. 105) shows the modes of admission. The proportions of the three modes were about the same as in Group I.

Previous Suicidal Attempts. 18 of the 66 men, and 44 of the 101 women, had a history of previous suicidal attempts. It was not possible to establish how many of those attempts had resulted in admission to hospital.

Seriousness of the Attempt. Some confusion exists in the psychiatric literature on this point. Suicidal attempts are usually called serious when injury and danger to life are considerable. However, such attempts were not always ' meant seriously ', i.e. the intent may have been moderate or even slight. On the other hand, ' seriously meant ' attempts have been called serious even if the degree of injury and the danger to life were small. Recently, Schmidt *et al.* (1954) proposed to call those attempts serious in which the self-inflicted injury was severe, and also those in which, in the psychiatrist's view, the intent had been serious though the injury inflicted was slight. Before adopting such a classification it seemed necessary to consider the degree of injury and the degree of intent separately. In each case of this series the degree of injury and of danger to life were assessed and scored, independently of the degree of intent which was scored separately.

Four degrees of dangerousness have been differentiated.

1. *Absolutely dangerous.* These were attempts which caused temporary or permanent severe injury and danger to life and would have done so in any circumstances ; e.g. planned gassing resulting in coma, poisoning with a very large dose of drugs resulting in coma, jumping in front of a train, etc.

2. *Relatively dangerous* were those methods which, though not necessarily highly dangerous, did in fact seriously endanger life, or could have done so. This is the type of attempt that might have proved fatal but for intervention which, with foresight, could have been guarded against. For instance, if a patient had taken a large dose of narcotics, but immediately told his wife that he had done so, thus mobilizing counteraction, such an attempt was called ' relatively dangerous '. Under unfavourable conditions it might well have been fatal, and there had been considerable risk to life.

3. *Relatively harmless* were attempts which in the circumstances prevailing were unlikely to cause serious injury or threat to life. Turning the gas on with the windows open and with members of the family in the same house, or walking into the river under the eyes of onlookers, or cutting the wrist superficially, or taking a large, but not for the average person dangerous, dose of narcotics—these methods

would prove serious threats to life only in very unfavourable circumstances, not otherwise.

4. *Absolutely harmless* is self-explanatory.

Each patient and, where possible, his relatives or other informants were questioned on these points and the attempt was assessed accordingly.

Degree of Intent. This was assessed on the patient's statements to the psychiatrist (E. S.). Relevant utterances reported by the relatives were also taken into consideration, and so were the circumstances surrounding the attempt, including the patient's behaviour immediately before, during and after. In addition, the background of the suicidal attempt and its history were reviewed for evidence of the seriousness of the intent. Obviously, the assessment of the degree of intent, unlike that of dangerousness, was subjective rather than objective.

Three degrees of suicidal intent were distinguished: serious, medium, slight. The first was regarded as having been present in those cases where an unambiguous impulse to suicide was admitted and also borne out by the patient's behaviour throughout the act. The second degree (medium) applied to suicidal attempts associated with a definite though wavering urge to self-destruction. The third degree (slight) applied to attempts in which such an impulse was superficial and/or fleeting.

The criteria used for this are mainly behavioural and refer to the patient's conscious intentions and motives. To say that the intent was slight because the patient followed a fleeting impulse only and immediately took steps to undo the suicidal act, does not imply a denial of a deep-seated and persistent, but unconscious suicidal urge.

The scoring for dangerousness and intent was carried out independently by the two authors. Where there was a discrepancy the case was carefully reviewed and discussed and an agreed score decided upon. The following cases are examples.

Case 32. A 79-year-old widow, with hypertension and heart failure, had been depressed for twelve months. She was alone in the house and her daughter, with whom she lived, was not expected back before 12.30 p.m. The daughter returned an hour earlier and found her mother in the gas-filled kitchen lying on the floor semi-comatose. Windows and doors were shut. She declared that she wished to kill herself as she was unwanted. Grading: *absolutely dangerous, with serious intent.* A similar method used in the same circumstances by a younger person might have been graded as only relatively dangerous.

Case 33. A 59-year-old woman suffering from depression with cancer phobia was late at night found crawling on hands and knees in the Thames four miles from home. Her depression had been precipitated by her daughter's death. Grading: *absolutely dangerous, with serious intent.*

Case 34. A 58-year-old spinster had been depressed for some months and had had a course of electroconvulsive treatment. She was still depressed a month after discharge from hospital. At breakfast she took a

large dose of sleeping capsules, but immediately called her sister with whom she was staying and told her what she had done. She was taken to hospital unconscious. She had taken the drugs after a fleeting suicidal impulse, and had not seriously intended to take her life. This was borne out by her behaviour. From the observation ward she was transferred to a mental hospital. The diagnosis in this case was involutional depression. Her attempt was graded as *absolutely dangerous, with only slight intent.* Had her sister not been available the attempt would probably have proved fatal.

Case 35. A 50-year-old woman suffering from depression after the death of her mother on whom she had been greatly dependent, made a suicidal attempt after she had been disappointed in her hope of living in her married sister's home. She jumped from the first-floor window, dislocating her left humerus. She remained depressed and expressed profound regret that she had not killed herself. Grading : *relatively dangerous, with serious intent.*

Case 36. A 66-year-old man with severe depression, emphysema due to long-standing asthma, and epileptic fits, left the common bedroom one winter morning before 6 a.m. while his wife was asleep, went downstairs into the kitchen and turned on the gas. Soon afterwards his wife, who used to get up at 8 a.m., woke up, looked for him and found him lying dazed on the kitchen floor. The gas meter was empty but the amount of gas which had escaped was small. In hospital he was found to be severely depressed and there was no doubt about the seriousness of his suicidal intentions. Degree of danger : *relatively dangerous* in view of his age and frailty. Intent : *serious.*

Case 37. A 40-year-old woman had been depressed after her husband's admission of infidelity. She took 100 tablets of codein-phenacetin compound when alone at home but knew that her son would come soon and she expected that he would find her alive. She admitted having thought of suicide but also of scaring her husband and making him decide between herself and the other woman. Her son arrived as expected and she was taken into hospital in a state of toxic confusion. The attempt was graded as *relatively dangerous, with slight intent.*

Case 38. A 35-year-old man was jilted by his fiancée. In a state of severe reactive depression he took a very large dose of barbiturates at a coffee stall. He collapsed in the street, unconscious. He had collected the drugs with the intention of killing himself. This attempt was classified as *relatively dangerous,* in view of the site of the attempt. The attempt would have proved fatal had it been made in different circumstances. The intent was scored as *serious.*

Case 39. A 40-year-old male schizophrenic left home in a state of depression. He was brought home by the police ; though watched, he slipped away and locked himself in the lavatory. He opened the door only after his wife had implored him to do so. He had a towel round his neck soaked in blood ; there were two long cuts through the skin. He declared that he had made the suicidal attempt ' as an act of faith, to prove whether God wanted him to live or die '. Grade of danger : *relatively harmless.* Seriousness of intent : *medium.*

Case 40. A 59-year-old married man, who could not do the arithmetic needed in his work accurately, had just returned home after trying to give himself up to the police for this imaginary ' fraud '. He found representatives of his firm, who had been notified by the police, at his home. He tried to strangle himself with a handkerchief, and struggled when restrained. He had been for some time in a state of agitated depression over his work failure and felt he had deceived his wife by not telling the true facts about it. At the time of the attempt, he said, ' I am finished—it is no use going

on.' He was transferred to a mental hospital. Diagnosis was involutional depression. Scoring: *relatively harmless, with serious intent.*

Case 41. A 30-year-old unmarried woman had been with a man to a club where she got drunk and excited. He left her because of this. She went to a frequented night post-office where she bought a postcard and wrote a farewell note to the man. She then took nine aspirin tablets and collapsed in the post-office. The officials called the police. In the observation ward she stated that she wanted to kill herself at the time, but also realized the appeal character of the attempt. Grading: *absolutely harmless, with slight intent.*

Table 18 demonstrates that in Group III the proportions of patients of each sex whose methods were absolutely and relatively dangerous were almost identical. Absolutely harmless methods had been chosen only by female members of this group.

TABLE 18

GROUPS III *and* V. *Degrees of Dangerousness*

	Men		Women	
Group	III	V	III	V
No. of Patients	66	26	101	50
Absolutely dangerous	21	6	30	18
Relatively dangerous	27	15	41	17
Relatively harmless	18	3	19	13
Absolutely harmless	—	1	6	2
Unknown	—	1	5	—

Table 19 shows the incidence of the various degrees of intent among Groups III and V. In the former the proportions of each sex whose intent was serious were almost identical.

In Table 20 (p. 88) the four degrees of dangerousness are related to the main diagnostic groups (schizophrenia, manic-depressives, other

TABLE 19

GROUPS III *and* V. *Degrees of Intent*

	Men		Women	
Group	III	V	III	V
No. of Patients	66	26	101	50
Serious	26	9	42	25
Medium	29	11	35	16
Slight	10	5	19	9
Unknown	1	1	5	—

TABLE 20

GROUP III. *Degrees of Dangerousness among the Diagnostic Groups*

Total			Absolutely Dangerous		Relatively Dangerous		Relatively Harmless		Absolutely Harmless		Unknown	
M	F		M	F	M	F	M	F	M	F	M	F
9	11	Schizophrenia	5	4	2	6	2	1	—	—	—	—
21	35	Manic-depressives, incl. involutional depressives	5	15	10	12	6	3	—	2	—	3
19	34	Other depressions—reactive, neurotic	7	7	9	13	3	10	—	4	—	—
—	4	Senile psychosis	—	2	—	—	—	—	—	—	—	2
4	—	Other organic reactions	—	—	2	—	2	—	—	—	—	—
13	17	Psychopathic reactions	2	2	5	10	6	5	—	—	—	—
66	101		19	30	28	41	19	19	—	6	—	5

depressions, psychopathic reactions). Only a minority (30%) had used absolutely dangerous methods, even among the schizophrenics and the depressive psychoses, although their proportion was larger in those diagnostic categories than among psychopathic reactions and other depressions. However, the figures for absolutely and relatively dangerous methods together amounted to a majority among the various degrees of dangerousness found in each diagnostic group. It is noteworthy that in this sample the proportion was higher among women.

Of 11 epileptics (5 male, 6 female), 4 (2 of each sex) used absolutely dangerous methods. 6 (3 of each sex) used relatively dangerous methods, 1 woman used a relatively harmless method.

TABLE 21

GROUP III. *The Incidence of the Various Degrees of Intent among the Diagnostic Groups*

Total			Serious		Medium		Slight		Unknown	
M	F		M	F	M	F	M	F	M	F
9	11	Schizophrenia	6	6	2	2	1	1	—	2
21	35	Manic-depressives, incl. involutional depressives	10	21	9	9	2	4	—	1
19	34	Other depressions	7	9	8	17	4	8	—	—
—	4	Senile psychosis	—	1	—	1	—	—	—	2
4	—	Other organic reactions	1	—	2	—	—	—	1	—
13	17	Psychopathic reactions	2	4	8	7	3	6	—	—
66	101		26	41	29	36	10	19	1	5

Table 21 shows the various degrees of intent and their incidence among the diagnostic groupings. In about 40% of the total, the intent had been serious, but the percentage was higher among the women. In an equal proportion of the total the intent had been medium, but in this category the proportion of men was higher than of women. Among the schizophrenics and the depressive psychoses a majority of the attempts had been undertaken with serious intent.

Table 22 shows the correlations of the different degrees of dangerousness with the three degrees of intent. Only among the 'absolutely dangerous' attempts had the degree of intent been maximal in a majority. In one-fifth of the patients the highest degree of dangerousness was associated with only a medium degree of intent. On the other hand, serious intent was frequently associated with but a relatively

TABLE 22

GROUP III. *Degrees of Dangerousness Related to Degrees of Intent*

Degree of Dangerousness	No. of Patients		Degree of Intent							
			Serious		Medium		Slight		Unknown	
	M	F	M	F	M	F	M	F	M	F
Absolutely dangerous . .	21	30	16	22	5	5	—	1	—	2
Relatively dangerous . .	27	41	9	16	16	18	2	7	—	—
Relatively harmless . .	18	19	1	1	8	10	8	7	1	1
Absolutely harmless . .	—	6	—	1	—	1	—	4	—	—
Unknown	—	5	—	2	—	1	—	—	—	2
Total	66	101	26	42	29	35	10	19	1	5

dangerous method. The two lowest degrees of dangerousness were as a rule associated with a medium or low degree of intent.

Among the 11 epileptics (5 male, 6 female) there were 6 (2 male, 4 female) with serious intent, 3 males with medium and 2 females with slight intent.

Table 23 relates dangerousness and intent in the four main diagnostic groups. It is noteworthy that among the cases classified as psychopathic reactions no absolutely harmless methods were used. Among the neurotic and reactive depressions 4 women only used such methods. Organic reaction types were not included in this table because of their very small number.

The proportions of patients in each diagnostic group who used dangerous methods, i.e. those classified as either absolutely or relatively dangerous, were as follows: schizophrenia 85%, endogenous depressions 75%, other depressions 67%, psychopathic reactions 63%.

TABLE 23

GROUP III. *Degrees of Dangerousness Related to Degrees of Intent in the Four Main Diagnostic Groupings: Schizophrenia (S), Manic-depressives and Involutional Depressives (D), Reactive and Neurotic Depressions (RN), and Psychopathic reactions (P)*

	Diagn.	No.	Ser.	Med.	Sl.	N.K.
Absolutely dangerous . . .	S	9	6	1	1	1
	D	20	17	3	—	
	RN	14	9	4	1	
	P	4	4	—	—	
Relatively dangerous . . .	S	8	5	2	1	
	D	22	11	9	2	
	RN	22	7	12	3	
	P	15	1	11	3	
Relatively harmless . . .	S	3	—	1	1	1
	D	9	1	5	3	
	RN	13	—	8	5	
	P	11	1	4	6	
Absolutely harmless . . .	S	—	—	—	—	
	D	2	1	—	1	
	RN	4	—	1	3	
	P	—	—	—	—	
Unknown	D	3	1	1	—	1

Site of Attempted Suicide. The patient's relationship to the social environment during the suicidal act is illustrated in Table 12. Clear information concerning this aspect was available for 59 men and 88 women, of whom 24% and 30·1% respectively were alone at the time of the attempt. The nature of that isolation was further analysed (Table 13, p. 71). 'Special persons' referred to in the table were spouse, fiancée, lover, friend or colleague in a special relationship to the patient, while 'others' are just members of the community, i.e. neighbours, passers-by, fellow-travellers, policemen.

The dangerousness of the method has been related to whether or not the patient was alone, i.e. neither with or near people, during the attempt. Of the 14 men alone, 12 (85%) and of the 30 women alone, 21 (70%) used absolutely and relatively dangerous methods, while of those not alone, i.e. 52 men and 71 women, 35 (67%) and 50 (71%) used such methods.

Table 24 shows that the proportion of absolutely dangerous methods among the men who were alone was much smaller than among those

TABLE 24

GROUP III. *The Proportions of Dangerous Attempts made by Patients Classified 'alone' during the Attempt, and others*

	Alone		Others	
	M 14	F 30	M 52	F 71
Absolutely dangerous	3	9	17	21
Relatively dangerous	9	12	18	29
	12 85·7%	21 70%	35 67·3%	50 70·4%

not alone, whereas among the women it was about equal. However, if both degrees of dangerousness were added together the proportion of dangerous attempts among men who were alone was higher than among those who were not alone.

Movement during the Suicidal Attempt. Information about this point was available for 60 men and 90 women. 14 (23·3%) of the former and 26 (28·9%) of the latter, i.e. a total of 40 (26·7%), moved towards others during the suicidal act. Among them the proportion of those who were 'alone' during the attempt was not higher than among the rest.

Only 4 men and 2 women moved away from others during the suicidal act, i.e. 4·6%.

Agent Intervening. Table 14 (p. 71) shows the various agents intervening to prevent death or immediate repetition of the attempt. In about one-quarter of the total group this was the patient himself. 'Expected special persons' or 'others' were known, or could have been known by the patient to be likely to appear on the scene at or within a certain time of the suicidal act. This ranged from a few minutes to several hours. In some instances the arrival of the expected person was part of the plan of the suicidal act and a few admitted that they had expected intervention. To others this likelihood did not occur at the time, and the majority genuinely expected to be dead before the return of the expected person. The knowledge of the impending arrival of another person does not, of course, imply a low degree of intent; extremely dangerous attempts are sometimes made in the presence of others.

People who appeared on the scene accidentally were either special persons who appeared earlier than expected, or people who had not been expected, or people who witnessed the suicidal act, such as those who happened to be present in the frequented public places so often

chosen by the patients. Their intervention, though accidental, was not entirely improbable. It is not surprising to find in a series of patients taken to hospital after the suicidal attempt so large a majority of cases where there had been an intervening agent. Among those not admitted to hospital there must be many who survive suicidal attempts without any intervention. This applies especially to those using drugs.

Tendency to Repetition related to Dangerousness and Intent. The question was examined whether the tendency to repetition of suicidal attempts was related to degree of dangerousness and of intent of the present attempt. The incidence of attempts of various degrees of dangerousness and intent among those who had made at least one suicidal attempt previously, was compared with their incidence among the rest. No marked differences emerged.

5 men and 9 women had made more than two previous attempts. Among these, the present attempt had been absolutely dangerous in 2 men and in 3 women and relatively dangerous in 3 men and 1 woman. The intent had been serious in 1 man and 6 women, medium in 4 men and slight in 3 women. No conclusion can be drawn from these figures except that they fail to bear out the commonly held idea that repeated suicidal attempts tend to be relatively harmless. It was not possible to compare the degrees of dangerousness and intent of the present and previous attempts as the latter could not be graded.

Disposal. The proportion of those discharged home and transferred to other psychiatric hospitals was the same as in Group I. It is noteworthy that the percentage of those transferred to other psychiatric hospitals, i.e. 70%, was about the same as that among the total admissions of the observation ward. However, the proportion of patients of Group III who were transferred certified (26 of 117, i.e. 22% of those transferred) was smaller than the corresponding proportion of the total of those transferred from this observation ward to mental hospitals during the period under survey. 491, i.e. 30%, of 1,586 transferred had to be certified.

CHAPTER 12

GROUP IV. 174 ADMISSIONS FOR ATTEMPTED SUICIDE TO ST. PANCRAS' HOSPITAL OBSERVATION WARD FROM 1ST JANUARY 1953 TO 31ST DECEMBER 1953

ST. PANCRAS' OBSERVATION WARD serves mainly the northern parts of the capital. It has the same capacity as St. Francis' Observation Ward, i.e. 82 beds,* half for each sex. The number of admissions during 1953 was 1,444 (826 (57%) male and 618 (42%) female). This atypical sex ratio was due to administrative anomalies: owing to staffing difficulties the number of female beds available for use was most of the time smaller than the number of male beds; also, owing to shortage of beds in the female wards of some mental hospitals the transfer of female patients was often held up for a considerable time. The absence of these factors in the male section resulted in a larger turnover of male patients.*

The records of 1,408 (97·5%) patients were examined, of whom 806 (57·3%) were male and 602 (42·7%) female. There was no indication that the remaining 36 patients whose notes were not available at the time were in any way a selected group. None of the patients of this group was interviewed by the authors. Although for the reasons mentioned above, and others referred to earlier (p. 33), this group cannot be regarded as representative of the attempted suicide population, it seems, nevertheless, profitable to compare it with the others presented earlier.

Composition of the Group. 177 patients were, in the course of the year 1953, admitted because of a suicidal attempt. 97 were male and 80 female.

Age Distribution. This is demonstrated in Table 30 (p. 107). The number of patients over 60 was 29. The most highly represented age-group was that of 25–34 among the men, and that of 25–34 among the women.

Marital Status. In this group, also, the number of those living without a marriage partner was 59·6% (Table 29, p. 106).

Isolation. The number of those falling into the categories of isolation was 62 (35·6%), i.e. even higher than in Group III.

Religious Affiliations. Church of England 100, Roman Catholic 38, Non-conformist 12, Jewish 12, other religions 3, atheist 3, not known 9.

Social Class. Table 31 (p. 108) shows the social class distribution

*See Postscript, p. 95.

for men. Compared with the population of Greater London, the higher classes were still under-represented although less so than in Group III. This difference may have been due to the fact that the area served mainly by this observation ward contained more well-to-do districts than the area mainly served by St. Francis' Observation Ward.

Modes of Admission. The frequency of the various modes of admission differed from that found in Group III, the proportions of men admitted through the police and that of women admitted through the Duly Authorized Officer being larger. The comparatively larger proportion of alcoholics among the men may have been responsible for the more frequent intervention of the police compared with Groups I and III.

Diagnoses (Table 33, p. 112). The proportion of schizophrenics was higher and the proportion of endogenous depressions lower than in Group III. The diagnosis of psychopathic reaction was made even less frequently than at St. Francis' Observation Ward. Of the 'other depressions', only 8 (2 male, 6 female) were not obviously reactive.

6 men and 1 woman were epileptics. 5 women were described as mental defectives.

22 men and 13 women were classified as alcohol addicts, a considerably higher proportion than in Group III.

2 men and 6 women were drug addicts. This category was not represented in Group III.

The number of patients known to have been previously admitted to a mental hospital was 53 (28 male, 23 female).

Seasonal Fluctuations. The incidence of suicidal attempts in the successive months was as follows: 14, 11, 15, 16, 8, 16, 7, 22, 12, 18, 13, 25. There was an unusual peak in December, possibly due to fluctuations in the number of available beds, but the very high rate of isolation which exceeded that of the other groups may also have played a part; loneliness is likely to be experienced as more painful at this particular season.

Methods. The proportion of patients who used drugs (Table 32, p. 110) was even higher than in Group III. The difference between the number of methods shown in the table and the number of patients was due to the fact that several patients used more than one method.

Dangerousness and intent could not be assessed in this group as the patients were not interviewed by a member of the team. For the same reason, the social constellation at the time of the act could not be established.

Previous Suicidal Attempts. In 23 out of 97 men and in 26 out of 80 women, there was a history of previous suicidal attempts.

Disposal. Of the 177 patients (97 male, 80 female) making up the group, 92 (56 male, 36 female) were discharged from the observation

ward. 81 (39 male, 42 female) were transferred to mental hospitals, and 3 (1 male, 2 female) to general hospitals. No patient died in the observation ward.

The proportion of patients transferred to mental hospitals was 45·8% against 70% in Group III. This difference was due to a variety of factors, the most important of which were : the presence in Group IV of a considerable number of alcoholics and drug addicts who would be discharged after only a short period of observation. There were far fewer admissions of this type in Group III. Another important factor responsible for the larger number of transfers to mental hospitals in Group III than in Group IV was the closeness of the Bethlem Royal Hospital and the Maudsley Hospital with which St. Francis' Hospital is intimately associated. Many patients who would not have consented to seek admission to an ordinary mental hospital as voluntary patients, willingly went into the Bethlem Royal or the Maudsley Hospital to which almost none of the 'stigma' inevitably attached to mental hospitals serving a certain area adheres, and which, as a university hospital, has a considerable reputation among the population.

Postscript. Dr. E. W. Dunkley, Consultant Psychiatrist in charge of St. Pancras, Observation Ward, kindly commented on this report and gave some additional information. In 1953 the total number of beds in use had been 76. The atypical sex ratio had been a permanent feature of this observation ward. A large number of men living in isolation were admitted ; most of these could be quickly discharged. The close proximity of four railway termini accounted for many of these admissions. In contrast, very few females were admitted as of no fixed abode or from lodging houses. The proportion of females suffering from typical mental illness was much higher than among the males.

Chapter 13

GROUP V. 76 PATIENTS ADMITTED FOR ATTEMPTED SUICIDE TO DULWICH HOSPITAL FROM 1st JANUARY 1951 TO 31st DECEMBER 1953

DULWICH HOSPITAL is a general hospital in south-east London with a capacity of 400 beds. It was arranged that during the period under survey every admission for attempted suicide should be seen by the psychiatrist in the team. It is possible that sometimes he was not consulted, so that a proportion of the relevant patients may not have been included. This applies particularly to patients admitted to the surgical department. Another group not included were those admitted to hospital unconscious and dying there without recovering consciousness. Otherwise, the series was unselected and presents a sample of patients admitted to a general hospital after suicidal attempts and fit to be psychiatrically examined.

The Composition of the Group and Mode of Admission. The group consisted of 26 men and 50 women. 29 patients (11 male, 18 female) had been admitted through the police ; 5 of them (2 male, 3 female) from a public place, the rest from their homes.

With 33 patients (13 male, 20 female) a medical practitioner had been involved in the admission. With 26 (9 male, 17 female) no general practitioner had intervened, and with 17 patients (4 male, 13 female) it was uncertain whether a doctor had played a part in the patient's admission. At any rate, 43 of the patients (14 male, 29 female) were known to the police. Of 27 (10 male, 17 female) the police had no knowledge, and with 6 it was uncertain whether this was so. It was not possible to ascertain in how many cases criminal proceedings were instituted. In the large majority, it was recorded that no proceedings were taken.

Age Distribution. Table 30 (p. 107) shows the age distribution. 18 patients, i.e. 23·6% (7 male, 11 female), were 60 years and over. The age distribution among males was about the same as in the other groups, but among the females there was instead of the usual peak in the 25–34 group a plateau extending from 25 to 44, followed by a deep drop in the age-group 45–54. In view of the smallness of the group no conclusions can be drawn from these discrepancies at present.

Marital Status and Modes of Life. The marital status among the group is shown in Table 29 (p. 106). 28 women, but only 1 man, lived in isolation.

Religion. 65 patients belonged to the Church of England, 4 were Roman Catholics, 3 Non-conformists, and 3 belonged to other Christian religions. The religious affiliation of one patient was unknown.

Social Class. This was established among the men only as no control figures are available for women. The representation of the five social classes among the 26 men is shown in Table 31 (p. 108). The group by itself is too small for the data to be significant but it is noteworthy that in this group, too, the two upper classes were underrepresented, but the representation of Class III was the same as among the general population.

Diagnostic Classification. Table 33 (p. 112) shows that the number of psychotic reactions was 23 (4 male, 19 female), i.e. less than one-third of the total, which is the proportion of psychotics usually found among unselected samples of suicides. Among those classified as 'other depressions (reactive and neurotic)' only 2, both females, appeared to be typically neurotic depressions, while the rest were reactive, i.e. clearly related to a traumatic situation. There was only 1 schizophrenic in this group which is not surprising: this type of patient is likely to appear mentally ill and therefore to be sent directly to a psychiatric department.

Alcohol addiction was present in 4 men while alcohol played a part in the suicidal attempt in 6 other men and 1 woman.

Seasonal Fluctuations. The following were the admissions during the twenty-four months period, each of the twelve figures representing admissions during two corresponding months, i.e. January 1951 and 1952, and so on: 8, 4, 9, 3, 9, 6, 9, 4, 7, 7, 6, 4.

Previous Admissions to Mental Hospitals. 3 men and 10 women were known to have been treated in a mental hospital previously; 1 man and 4 women had previously been in a mental observation ward.

Previous Suicidal Attempts. This information was available about 74 patients. 16 (4 male, 12 female), i.e. 21%, were known to have made suicidal attempts before.

The Rôle of Physical Illness. No attempt was made to study the motives for the suicidal attempt in this group, except for the rôle played by physical illness, which appeared to have formed the main motive with 7 patients (5 male, 2 female). With 10 (3 male, 7 female) it was a factor, and 16 patients (7 male, 9 female) complained of symptoms of physical illness at the time of the attempt though not declaring them as motives.

Site of the Suicidal Attempt. This could be ascertained for all but 8 patients (Table 12, p. 70): 25 (6 male, 19 female) had been alone in house, flat or workplace when they tried to take their lives.

Nearness of Others during the Attempt. The social setting of the attempt is shown in Table 13 (p. 71).

Movement towards others during the attempt took place in 25 instances (9 male, 16 female).

Agent Intervening. Table 14 (p. 71) shows the agent intervening in the suicidal act.

Methods Employed. In this group, also, narcotics headed the list. The proportion of patients who used drugs was in fact higher than in any other group (Table 32, p. 110). This is not surprising, considering that patients in a state of drug poisoning will almost automatically be taken to a general hospital rather than to a psychiatric hospital. A higher proportion of men than women used gas and narcotics; 3 female patients used multiple methods.

Dangerousness of the methods employed and seriousness of intent are shown in Tables 18 and 19 (p. 87) which demonstrate that the incidence of seriously intended attempts was higher than that of attempts graded as absolutely dangerous. Comparatively more women used absolutely dangerous methods with serious intent than men, but relatively more women used relatively harmless methods. 19, i.e. one-quarter of the whole group, had employed methods regarded as absolutely or relatively harmless. This shows that the degree of injury inflicted was for a considerable proportion not the chief reason for admission to hospital. Fear of repetition and other emotional reactions of the environment must have played a considerable part in these admissions.

In Table 25 dangerousness of method is related to degree of intent. It shows how frequently serious intent was associated with an only relatively dangerous method.

Dangerousness and Diagnosis. If the degrees of dangerousness were related to diagnosis, whereby absolutely and relatively dangerous methods were taken together, the endogenous depressions headed the list with 83·3%, followed by 'other depressions' with 68·8% and psychopathic reactions with 62·5%.

TABLE 25

GROUP V. *Degrees of Dangerousness Related to Degree of Intent*

Degree of Dangerousness	Number of Patients		Serious		Medium		Slight		Not known	
	M	F	M	F	M	F	M	F	M	F
Absolutely dangerous	6	18	4	16	2	2	—	—	—	—
Relatively dangerous	15	17	5	8	7	8	3	1	—	—
Relatively harmless	3	13	—	1	2	6	1	6	—	—
Absolutely harmless	1	2	—	—	—	—	1	2	—	—
Not known	1	—	—	—	—	—	—	—	1	—
Total	26	50	9	25	11	16	5	9	1	—

Intent and Diagnosis. The diagnostic groupings were also related to seriousness of intent. The highest proportion of attempts with serious intent was found among the endogenous depressions and senile psychoses, the majority of which were depressive. 'Other depressions', most of them reactive, also showed a majority of attempts with serious intent. Among the psychopathic reactions both the degree of dangerousness and of intent were lower than in the other groups.

Disposal. About one-third of the patients were transferred to psychiatric wards. The proportion of women was markedly higher than that of men. 46 patients (19 male, 27 female) were discharged home, 18 (3 male, 15 female) were transferred to a mental hospital as voluntary patients, 9 (3 male, 6 female) to an observation ward, 2, both females, to a convalescent home, 1 man died from heart failure in Dulwich Hospital a week after his admission with a cut throat. The suicidal attempt probably contributed to his death.

Subsequent Suicides. No systematic follow-up of this group was carried out. Nevertheless, 3 subsequent suicides came to the knowledge of the authors; 2 were brought to Dulwich Hospital and the third committed suicide while on leave from the Maudsley Hospital where she was an in-patient. These suicides happened six weeks, two months and one year respectively after discharge from Dulwich Hospital. Whether more members of this group have since killed themselves is unknown.

Case 42. Mr. C. H., aged 54, a salesman, had a year before the suicidal attempt been treated for collapse of his lung and after his discharge was not as successful in his work as previously. He suffered from insomnia, which he tried to combat with alcohol and barbiturates. He was greatly concerned about the business and on 10.1.53 his wife was unable to rouse him from his sleep. He was taken into hospital in a coma, having taken a large overdose of phenobarbitone. The attempt was graded relatively dangerous, with serious intent, although the patient denied that he wanted to take his life.

In hospital he was depressed and expressed fear of losing his job. He was discharged after ten days and seen again as an out-patient a week later when he seemed only slightly depressed and anxious to resume work. A month later he was admitted to Dulwich Hospital with aspirin poisoning from which he died. In this case a variety of factors contributed to the fatal outcome: fear of physical illness, a tendency to addiction and probably others which it was not possible to explore.

Case 43. Mr. E. J., a 68-year-old widower, living with his daughter, was admitted on 3.11.1953 after trying to gas himself. He had for some years been suffering from pulmonary tuberculosis with cavitation and chronic bronchitis. He was deaf and had a hydrocele. Early in the morning he turned on the gas-ring in the kitchen but screamed shortly afterwards. His daughter got up and found him semi-comatose. On admission to hospital he was unconscious. When seen by the psychiatrist on the following day he was still depressed. He admitted that he wanted to take his life as he was fed up with his chest condition, but he denied further suicidal intentions. He said that he had screamed because his head was aching. His physical

condition was found to be stationary and he was discharged to the care of his relatives after 29 days. The attempt was graded as relatively dangerous, with medium intent.

On 1.1.1954 he threw himself in front of a train. He was brought in dead to Dulwich Hospital. Enquiries into the immediate antecedents of this suicide were not practicable.

Case 44. Mrs. G. A., aged 56, was admitted on 8.4.1953, after an attempt to gas herself. She recovered consciousness only after fifteen hours. She was depressed and expressed the delusion that she had neglected herself and had scabies as the result. She had been worrying about this for a month. She stated that she had turned the gas on at noon, her husband being expected back from work at 6 p.m. when he actually found her. The diagnosis was involutional depression. The attempt was graded absolutely dangerous, with serious intent. In hospital the patient was still depressed and blamed herself for the attempt. She was advised to go to the Maudsley Hospital for treatment but refused, and was handed over to her husband. She attended the Maudsley Hospital as an out-patient, but her condition failed to improve. She was persuaded to enter hospital on 16.6.1955. She expressed the delusion that she had venereal disease. She made several suicidal attempts while in hospital. In April she appeared less depressed. However, she had reason to believe that she was supplanted in her husband's affection by another woman. She did not discuss the subject with her husband for fear of breaking up the home. She was allowed home for the weekend and gassed herself when alone in the house.

Here a combination of factors contributed to the fatal outcome: the endogenous depression and the growing threat to her marriage. It appears that the patient succeeded in deceiving the doctors about her suicidal intentions. She seems to be an example of what has been called 'malignant suicide' (Farrar), but the persistence of the self-destructive urge was in this case maintained and reinforced by a new factor in her life, i.e. the open rejection by her husband and her displacement by another woman.

Chapter 14

GROUP S. 117 CASES OF SUICIDE

Some of the social aspects considered in this study of attempted suicide have never been investigated in connection with suicide. It therefore seemed desirable to have a control series of suicides in which those aspects could receive attention. The group chosen consisted of all cases of suicide on which an inquest had been held by the North London Coroner during 1953, i.e. the same year in which the suicidal attempts of Groups III and IV had taken place.

The North London Court serves 8 of the 28 metropolitan boroughs, with a total population of 846,190, according to the 1952 Census, and includes the area from which come the majority of admissions to St. Pancras' Observation Ward. This part of London contains some of the central districts of the capital, including the university. Sainsbury's (1955) ecological study was based on records of suicides which had come before this Court during 1936 to 1938.

In 1953 the number of suicides was 117 (73 male and 44 female).

Table 29 (p. 106) shows the marital status of the group. The most striking feature is the excessive number of widowed persons compared with the population of Greater London. In view of the smallness of the group and the considerable proportion of persons whose marital status was unknown, a more detailed comparison appears unprofitable.

Age-groups. The age distribution is shown in Table 30 (p. 107). Compared with the population of Greater London (Census 1952) the age-groups up to 44 were under-represented, the later age-groups over-represented. The higher the age-group, the higher the degree of over-representation : 77% of the men and 79% of the women were over 45. 42·5% of the men and 41·9% of the women were 60 years and over. The peak period was the age-group 55–64. These findings are in keeping with those of Swinscow (1952) who pointed out that the increased incidence of suicide among the elderly was responsible for the increase in the suicide rates.

Social Class. Table 31 (p. 108) shows the representations of the social classes among the men. The numbers are too small to be significant but it is noteworthy that of all groups studied by the present authors, in this group alone the upper classes were not under-represented, rather the opposite. This is in keeping with the observations made by Weiss (1953) and Sainsbury (1955) in suicide.

Isolation. The proportion of those falling into the category of isolation (42·7%) greatly exceeded the proportion in the general

population (7%) and even that found by Sainsbury (27%). 21 (14 male, 7 female) had recently moved house, 2 (1 male, 1 female) had lost their homes recently, and 5 (all male) felt such a loss impending. This was true for 4, the fifth had reason to expect such a loss.

Methods. Table 32 (p. 110) shows the methods employed by the group. The order of frequency of the main methods was in keeping with that for suicides in Greater London as a whole as shown in the report of the Statistical Branch of the Metropolitan Police. It differed from that in the attempted suicide group where drugs invariably headed the list.

Seasonal Incidence. The 117 suicides were distributed over the twelve months as follows : 11, 14, 15, 10, 6, 12, 5, 11, 9, 10, 7, 7. This sample, therefore, showed an earlier peak than is usually found.

Seriousness of Intent. As far as could be ascertained from the records, the intent had been serious in all. In 77 suicides, i.e. in 65%, special and often elaborate safeguards had been taken to ensure the fatal outcome : e.g. multiple methods, the sealing of doors, windows, chimneys, and the use of carefully designed apparatus. In the remainder there were other indications of determination to end their lives, including careful timing so that no one could intervene. In none had accident obviously played the main part in the fatal outcome, but as no full reconstruction of the circumstances of the suicidal act was attempted, this possibility cannot be excluded.

Sites Chosen for Suicide. These are shown in Table 12 (p. 70). The proportion of those who had taken care to remove themselves from other people when carrying out the suicidal act was much higher than among the attempted suicides. ' Others present in house ' refers to a situation when others were present in another part of the dwelling, the person concerned in a room by himself.

Degree of Isolation during the Suicidal Act. Table 13 (p. 71) demonstrates that slightly more than half the number of those who killed themselves had left their social environment, a much higher proportion than among the suicidal attempts.

Movement during the Suicidal Act. In one suicide only was there, in the records available, an indication of movement towards other people with the purpose of attracting attention ; this was a 78-year-old man in a state of profound depression after his wife's death three months earlier. Having cut his throat with a razor he thumped on his door giving his usual signal to his landlady to come, and calling for her. She arranged for his immediate admission to hospital where he died eleven hours later.

The possibility of similar movements having been made by others without achieving their aim cannot be excluded, but is unlikely in more than a few as the general tendency was towards isolation in the act of suicide.

The Discovery of the Suicide. Table 26 shows by whom the suicide was discovered. The number of those summoned or expected was very small. They were called for help but were to arrive after death. In 3 out of the 4 suicides in which other persons were summoned, they arrived when the person who had summoned them was already dead.

TABLE 26

GROUP S. *The Discovery of the Suicide*

	Men	Women	Total
Summoned by the individual concerned	2	2	4
By expected special person	3	4	7
Accidentally by special person	17	13	30
By others who were expected	1	2	3
Accidentally by others	49	23	72
Not known	1	—	1
	73	44	117

Suicide Notes. 18 men and 21 women left suicide notes. Of those 39, 18 (9 male, 9 female) gave their motives in these notes. Among the groups of attempted suicide the proportion of those who were known to have left notes was much smaller, but for a variety of reasons the information available was much less reliable.

Warning of Impending Suicide. 24 men and 16 women had given warning of their suicidal intention, either by talking about suicide in general or by threatening to kill themselves.

Known Previous Suicidal Attempts. In 17 suicides (14%), 11 male and 6 female, there was a history of previous attempts. 3 men and 2 women committed suicide with the methods used before. The reliability of the data concerning previous suicidal attempts is open to doubt. However, the witnesses were questioned about this point in every case. They are unlikely to have concealed previous attempts they knew of, as a history of previous attempts was likely to favour a verdict of unsound mind, for which relatives and friends in these cases almost invariably hope.

Previous Mental Hospital Treatment. 16 patients (10 male, 6 female) had been in mental hospitals before. The period since their discharge from the mental hospital ranged from a few days to eleven years. One had had a leucotomy for chronic depressive illness. It was not possible to establish the diagnosis for all, but the majority appeared to have been suffering from depressive illness. Of the 16 patients, 5 men and 1 woman had been admitted after a suicidal attempt. 2 male patients had been admitted to an observation ward for the same reason.

28 patients (14 male, 14 female) had been in general hospitals before, only one for attempted suicide.

Diagnoses. In only about one-third of the suicides was there an indication of a psychotic illness (Table 33, p. 112). The diagnoses had to be retrospectively inferred by the authors on the basis of the information recorded. By far the largest group appeared to have killed themselves in a state of reactive depression in which their motives could usually be discerned from the information available. It is most probable that among those listed as reactive depression were a number of psychopaths. Alcohol was recorded as having been taken at or shortly before suicide by 10 men and 2 women. 15 persons (11 male, 4 female) were reported to have been drinking to excess and 5 more (3 male, 2 female) probably did so.

Motives. It is not intended to discuss motives in detail as the information available was often obscure and incomplete. Certain motives recurred among this group which were not found among the attempted suicides presented earlier, such as bankruptcy or fear of it, or impending criminal proceedings for offences arising from business activities or for sexual misconduct. Obviously, the absence of some of these motives in the attempted suicide groups was partly due to their different social class stratification.

Physical illness was the main motive in 17 cases (9 male, 8 female) and a factor in causing suicide in a further 33 (20 male, 13 female). Another 24 persons (15 male, 9 female) were reported to have complained about physical symptoms a short time before killing themselves.

Chapter 15

SUMMARIES AND COMMENTS

A STATISTICAL ANALYSIS of the samples has not been one of the purposes of this research. Nevertheless, it seems worth while to compare, where possible, the samples with each other and with those of previous workers in respect of the factors usually investigated, before considering aspects not so far studied.

The Proportion of Admissions following Suicidal Attempts among Total Admissions. Groups I, II, III and IV comprised 10·2%, 6·3%, 10·5% and 12·2% respectively of the total admissions to the two observation wards in the periods under survey. Whether the larger percentage in St. Pancras' Observation Ward was due to the higher proportion of alcoholics admitted to this ward, or to other factors, it is impossible to say. Group II represented a smaller percentage of total admissions than the other groups, no doubt owing to selection. Group V could not be related to the total admissions to that general hospital.

It is possible, therefore, to infer that the proportion of admissions after attempted suicide to mental observation wards in London is likely to be about 10%.

Modes of Admissions to Observation Wards. Table 27 shows that the majority of the patients came from other hospitals, which is certainly not so for all admissions to observation wards. The proportion of men coming from general hospitals and *via* the police was higher than the corresponding proportion of women. The reasons for these differences must have been complex; the methods employed, the incidence of alcohol abuse, and the reactions of the environment probably played a part.

TABLE 27

GROUPS I, III *and* IV. *Modes of Admission to Observation Wards. Percentages in Brackets*

Group / Number in Group		I 138	III 167	IV 177
From other hospital	Male	49 (66·2)	48 (72·6)	71 (73·2)
	Female	41 (64·1)	66 (65·3)	49 (61·3)
Via police	Male	10 (13·5)	4 (6·1)	10 (10·3)
	Female	2 (3·1)	8 (7·9)	4 (5·0)
Via D.A.O.	Male	15 (20·3)	14 (22·2)	16 (16·5)
	Female	21 (32·8)	27 (26·7)	27 (33·8)

TABLE 28

Sex Ratio (percentages) in all Groups

Groups	I	II	III	IV	V	S
Male	53·6	27·8	39·5	54·8	33·3	62·4
Female	46·4	72·2	60·5	45·2	66·7	37·6

Sex Ratio. Among suicidal attempts women have usually been found to be in the majority. This was the case in Groups II, III and V, but not in Groups I and IV. The atypical sex ratio in the latter two groups was probably due to external circumstances which interfered with the normal flow of admissions. Group S showed the expected male majority.

Marital Status. In Table 29 the percentages of the kinds of civil status found in all groups have been listed. No conclusion can be drawn from these figures as they have not been corrected for age-groups. In view of the serious doubts about the representative

TABLE 29

All Groups. Marital Status (percentages)

	Male					
Group	I	II	III	IV	V	S
Number in Group	74	20	66	97	26	73
Single	27·0	40·0	39·4	40·2	16·0	8·2
Married	55·4	20·0	39·4	42·3	76·0	45·2
Separated	2·7	25·0	15·2	8·2	—	13·7
Divorced	—	—	1·5	4·1	—	1·4
Widowed	13·5	15·0	1·5	2·1	—	10·9
Cohabiting	1·4	—	3·0	3·1	4·0	2·7
Not known	—	—	—	—	4·0	17·9
	Female					
Group	I	II	III	IV	V	S
Number in Group	64	52	101	80	50	44
Single	26·6	34·6	23·9	31·3	26·0	18·2
Married	45·3	50·0	43·6	30·0	48·0	34·1
Separated	6·2	3·8	12·9	8·8	4·0	4·5
Divorced	3·1	—	0·9	5·0	—	4·5
Widowed	17·2	7·7	11·9	18·8	20·0	36·4
Cohabiting	1·6	3·8	6·9	5·0	2·0	2·3
Not known	—	—	—	1·2	—	—

character of our groups this seemed unprofitable. However, some correlations are worthy of comment. The proportion of single people was lower among the suicides than among the attempts. This is at least partly due to the higher average age among the suicides. Sainsbury (1955) found the married suicide rate to be higher than the single, but the married had a higher average age. The excessive proportion of widowed among the female suicides is noteworthy. Among the other groups this and other figures vary greatly. A comparison of the attempted suicide group with the total hospital population of which it forms a part was carried out in Group II for single persons and it was found that among that sample of persons who had attempted suicide the number of single persons was higher than among the rest of the hospital population. This is in keeping with the rôle isolation has been found to play in the causation of suicidal acts.

Age-groups. Table 30 shows the distribution of age-groups in all

TABLE 30

All Groups. Age Distribution, in percentages

	Male					
Group	I	II	III	IV	V	S
Numbers in Group	74	20	66	97	26	73
Age-group						
15–24	10·8	20·0	10·6	13·4	7·7	12·7
25–34	18·9	20·0	30·3	26·8	23·1	11·0
35–44	20·3	35·0	22·7	24·7	19·2	9·6
45–54	12·2	5·0	15·2	16·4	19·2	20·5
55–64	13·5	5·0	13·6	10·3	15·4	27·4
65–74	18·9	10·0	6·1	7·2	15·4	17·8
75–84	4·0	5·0	1·5	1·0	—	11·0
85–94	1·4	—	—	—	—	—
Unknown	—	—	—	—	—	—
	Female					
Group	I	II	III	IV	V	S
Numbers in Group	64	52	101	80	50	44
Age-group						
15–24	12·5	21·1	11·9	15·0	12·0	4·5
25–34	25·0	30·8	23·8	26·2	26·0	2·3
35–44	18·8	19·2	23·8	18·8	26·0	13·6
45–54	15·6	15·4	17·8	13·8	4·0	25·0
55–64	10·9	13·5	10·9	12·5	18·0	27·3
65–74	10·9	—	6·9	8·8	12·0	9·1
75–84	4·7	—	5·0	3·8	2·0	15·9
85–94	1·4	—	—	—	—	—
Unknown	—	—	—	1·3	—	2·3

samples. The peaks for the suicidal attempts were 24–44 in both sexes, earlier for women than for men within those two decades. In the suicide group the peak was 55–64 for both sexes. These findings accord with the observations of most other workers.

Comparison of the relative distribution of age-groups in a series of suicidal attempts with that in the rest of the hospital population of which they formed a part, was possible with the female section of Group II and with Group III. In the two latter the representation of the age-groups was identical with those among the respective total hospital population. These correlations deserve to be investigated systematically. It may well emerge that the correlations with age-groups which hitherto have been regarded as typical for suicidal attempts, are in fact identical with those among admissions to psychiatric hospitals in general. This would mean that liability to suicidal attempt corresponds to liability to mental disorder requiring admission.

Social Classes. The numbers of all groups studied were allocated to one of the five social classes distinguished by the Registrar-General for England and Wales according to occupations. It was possible to compare the class representation among the male sections of the groups with the social class distribution among the general population. Furthermore, the class distribution of one of the groups could be compared with that among the hospital population of which it formed a part. Table 31 shows the representations of the various social classes and relates them to that of Greater London.

The value of these figures is reduced by the smallness of the numbers and also by the fact that in three groups a sizeable proportion was unemployed at the time of the attempt and was therefore not allocated to a social class. Nevertheless, the figures show certain definite trends. Though there was no gross difference between the representation of the social classes among the suicide group and the general

TABLE 31

All Groups. Social Class Distribution among Males, in percentages, compared with that among the Male Population of Greater London (L) in 1952

Male Groups	I	II	III	IV	V	S	L
Number of males in each group	74	20	66	97	26	73	—
Class I	—	10	1·5	4·1	—	5·5	4·9
„ II	9·5	25	6·1	10·3	3·8	17·8	16·6
„ III	35·1	30	42·4	40·2	53·8	47·9	54·7
„ IV	14·9	5	7·6	12·4	7·7	8·2	10·7
„ V	28·4	10	16·7	25·8	7·7	8·2	13·1
No occupation	5·4	—	3·0	2·1	—	—	—
Unemployed	4·1	20	22·7	5·2	19·2	6·8	—
Unknown	2·7	—	—	—	7·7	5·5	—

population, the upper two classes, and to a lesser degree the third class, appeared to be under-represented among the attempted suicides admitted to the observation wards, i.e. Groups I, III, IV. Group II showed, for extraneous reasons discussed earlier, the same over-representation of the higher classes as the hospital population to which it belonged. In the general hospital sample (Group V) the first two classes were grossly under-represented, the third class showed the same representation as among the general population. The under-representation of the upper classes was less marked, though still quite definite, in Group IV than in Groups I and III; this was obviously due to the fact that the members of Group IV came from an area with a higher proportion of well-to-do than the area from which Groups I and III came. It seems very likely that the social class representation in Groups I, III, IV and V was also the same as among their respective hospital populations which came mainly from the working-class and lower middle class. At any rate, among the unselected samples of attempted suicide presented here, the upper classes tended to be under-represented compared with the general population. This contrasts with what has been found among suicides by Sainsbury (1955) and others. Weiss (1954), who used a different type of classification, found that in the population of New Haven, Conn., the suicide rates among members of the lower socio-economic classes were lower than among members of the upper classes.

It would not be justified to deduce from these figures that suicidal attempts are less frequent among the higher social classes than among the rest of the population. It seems probable that among the total admissions to mental observation wards, and even to public general hospitals, the upper social classes tend to be under-represented. For this and several other reasons it can be assumed that the great majority of attempted suicides occurring among the members of the upper socio-economic classes are not included in the kind of samples analysed. Such an assumption is in keeping with observations which can be made in general practice as well as in psychiatric private practice: suicidal attempts by persons belonging to well-to-do families result in admission to a public hospital mainly if they present a medical or surgical emergency. Otherwise they are either kept at home or admitted to private hospitals. The tendency to conceal suicidal attempts appears to be much greater among the upper than among the lower classes. Attempted suicide is probably as frequent, if not more frequent, among the former as among the latter, but only a small proportion of those members of the upper classes who make suicidal attempts are likely to appear among the samples available for study. This is another reason why none of these samples can be regarded as representative.

Religious Affiliations. All religious persuasions were represented but it was impossible to relate their proportions to those pertaining

to the population from which they came. The absence of Jewish patients in Group V is in keeping with the small number of Jews living in the area served by Dulwich Hospital.

TABLE 32

Methods. All Groups (percentages)

	Male					
Group	I	II	III	IV	V	S
Number in Group (Number of methods in brackets)	74(90)	20(33)	66(67)	97(106)	26(26)	73(73)
Method						
Coal gas	16·0	12·1	13·4	16·0	23·1	46·6
Disinfectant	6·6	—	1·5	—	—	2·7
Narcotic	12·2	18·2	32·7	31·1	57·6	10·9
Aspirin	6·6	24·3	8·9	13·2	7·7	1·4
Other poison	1·1	6·1	4·5	3·8	3·8	2·7
Wounding	30·0	12·1	23·8	17·9	3·8	2·7
Train and Vehicle	2·3	—	2·9	·9	—	5·5
Height	6·6	9·1	2·9	4·7	—	8·2
Hanging	13·3	6·1	2·9	1·9	—	8·2
Drowning	4·4	—	5·9	8·5	—	5·5
Shooting	—	3·0	—	—	—	4·1
Miscellaneous	1·1	9·1	—	1·9	3·8	1·4
Unknown	—	—	—	—	—	—

	Female					
Group	I	II	III	IV	V	S
Number in Group (Number of methods in brackets)	64(82)	52(83)	101(106)	80(92)	50(50)	44(44)
Method						
Coal gas	21·9	21·7	16·1	13·0	11·1	47·7
Disinfectant	11·0	—	3·8	1·1	3·8	—
Narcotic	21·9	27·7	31·1	46·7	47·2	20·4
Aspirin	11·0	16·9	7·5	4·3	24·6	2·3
Other poison	—	6·0	8·5	3·3	1·9	—
Wounding	7·3	6·0	9·4	13·0	5·7	2·3
Train and Vehicle	2·4	3·6	4·7	1·1	—	2·3
Height	12·2	6·0	6·6	4·3	5·7	18·2
Hanging	7·3	7·2	4·7	4·3	—	4·5
Drowning	1·2	3·6	6·6	2·2	—	—
Shooting	—	—	—	—	—	—
Miscellaneous	3·7	1·2	·9	5·4	—	2·3
Unknown	—	—	—	1·1	—	—

Methods. Table 32 above illustrates the well-known differences in the use of methods in suicides and suicidal attempts admitted to hospital. The difference between the use of narcotics in Group I

(1946) and in the later groups of suicidal attempts, i.e. those made after June 1949, is quite evident, as is the decline in certain other methods such as coal gas, wounding and hanging. The reasons for these shifts have already been referred to (p. 30). The easier availability of narcotic drugs was deemed the most important factor. The comparatively high percentage of men in Group V who attempted to gas themselves cannot be regarded as significant in view of their very small number. The much larger female section of this group showed the lowest proportion of gas poisoning among all groups.

Among the suicides, the comparatively small proportion of deaths by narcotic poisoning was noteworthy, especially among the men who formed the large majority of Group S. The easier availability of narcotics did not apparently cause a marked increase in suicidal deaths.

Diagnoses. The difficulties and ambiguities of any diagnostic classification of people who have made suicidal attempts have been pointed out earlier (p. 35) and make it unprofitable to compare the case material of different workers. The latest example of this difficulty is the study by Ettlinger and Flordh (1955) who surveyed 500 cases of attempted suicide admitted to a general hospital in Stockholm. They distinguished thirteen diagnostic divisions. Inevitably, the allocation of individual patients to only one of those categories is bound to be arbitrary as a considerable number of cases must have claims to inclusion in more than one. Nevertheless, some such schema is necessary as a frame of reference for limited use. A multidimensional diagnostic system would be the most satisfactory. It would have to take into account personality, mental illness, the precipitating circumstances and psychopathological peculiarities of the individual suicidal act. Such information is hardly ever available for large series of patients especially if they have not been examined with this particular problem in view. The present authors are aware that the broad classification they have chosen has many disadvantages, but this research does not aim at adding to the knowledge of the diagnostic aspects of suicidal acts. The authors will be satisfied if they have not added to the confusion. Even in the broad classification used here (Table 33, p. 112) the allocation of individual patients was sometimes arbitrary. Only in Group III were all conditions diagnosed by the same psychiatrist (E. S.); the conditions constituting Group V were diagnosed by him or by Dr. Kreeger; in all other groups the diagnoses were made by a considerable number of psychiatrists of varying experience.

The representation of the various diagnostic divisions in this material was on the whole in keeping with that observed by other workers in similar groups. The diagnoses in Group S (suicides) were

TABLE 33

All Groups. Diagnostic Classification

	Male					
Group	I	II	III	IV	V	S
Number in Group	74	20	66	97	26	73
Schizophrenia	7	4	9	16	—	2
Manic-depressive, involutional depression	17	3	21	25	1	17
Senile depression	4	1	—	7	3	2
Other depressions (reactive, neurotic)	23	10	19	32	17	46
Organic reaction types (confusional states, dementia)	8	—	4	3	—	—
Psychopathic reaction	15	2	13	14	5	3
Unknown	—	—	—	—	—	3

	Female					
Group	I	II	III	IV	V	S
Number in Group	64	52	101	80	50	44
Schizophrenia	6	7	11	17	1	—
Manic-depressive, involutional depression	23	15	35	19	11	19
Senile depression	5	—	3	5	5	4
Other depressions (reactive, neurotic)	22	23	34	25	28	16
Organic reaction types (confusional states, dementia)	2	—	1	3	2	—
Psychopathic reaction	6	7	17	10	3	5
Unknown	—	—	—	1	—	—

inferred from the data available at the inquests which could sometimes be supplemented by records obtained by the authors from hospitals in which the deceased had been patients.

Alcohol. The proportion of patients who were excessive drinkers was much smaller than in Batchelor's series in Scotland (1954) and in the groups studied by the Swedish workers. Those authors were at an advantage in enquiring about the rôle of alcohol in suicidal acts, as they saw all their patients shortly after admission. The majority of the patients of this research had been transferred from other hospitals, sometimes several weeks after their suicidal attempts. The differences between Groups III and IV were obviously due to differences in their catchment areas, which for the latter group included the centres of entertainment. Although the available figures concerning excessive drinking and the rôle of alcohol in the suicidal acts

were probably underestimates, alcohol abuse is unlikely to play as great a part in causing suicidal acts in England as it seems to in other countries, especially in Sweden.

Seasonal Fluctuations. In all groups except Group IV there was a fairly marked peak in admissions for attempted suicide in one of the spring months, similar to the seasonal increase in suicide. The absence of this feature in Group IV might have been due to interference with the flow of admissions.

Family Background. A varying proportion had a history of suicidal acts in the family, but the data obtained can hardly be regarded as reliable. Enquiries about broken homes were made in Groups I and II and the information has been commented upon. This is a question much in need of further study. Some of the difficulties have been pointed out (p. 17). It is likely that parental loss and discord play an important part in the origin of suicidal acts, but they also play a part in the origin of other types of abnormal behaviour. The problem is whether proneness to suicidal acts can be isolated and related to etiological environmental factors such as the ' broken home '. So far nobody has succeeded in doing this.

Dangerousness and Intent. The concept of ' serious suicidal attempt ' has varied greatly. The attempt of Schmidt *et al.* (1954) to define it was mentioned in the survey of the literature (p. 24). No grading for seriousness of large groups of suicidal acts can be really satisfactory, as unconscious motivation cannot be taken into account, quite apart from uncertainty about the patient's truthfulness. Clearly, the degree of danger to life is not a reliable measure of seriousness of intent, especially with poisoning, i.e. in the majority of suicidal acts. It was therefore decided to separate danger to life and degree of intent and relate them to each other. This could be done in two groups only, i.e. in those where the patients were questioned by one of the investigators shortly after the attempt. The results of these enquiries (Tables 18 to 24, pp. 87 ff.) can be summed up as follows: only in a minority of patients had danger to life and degree of intent been maximal. This was true for both groups investigated, i.e. Group III, a mental observation ward group, and Group V, a general hospital group. This, and other data presented, showed that with the majority of patients belonging to these groups a high degree of dangerousness or intent were not decisive for admission. Other factors, especially the reactions of the environment, must have been important. This was confirmed by the observation that with a number of patients previous attempts, apparently as serious, had not resulted in admission. This research has failed to bear out the belief that only ' serious ' attempts lead to admission to hospital. The real reasons are often far from transparent. A systematic investigation into this problem is being carried out by the present writers.

There was no indication that in the two groups where this question could be examined, a tendency to repeat suicidal attempts went with any special degree of danger or intent for the attempt under investigation.

The outcome of the attempts classified as absolutely or relatively dangerous, i.e. the patients' survival was, in the majority of cases, due to the reactions of the environment. In assessing the risk of suicide, therefore, the likelihood and chances of such reactions have to be taken into account.

At this stage of research, no prognostic inferences can be made in individual cases from the degree of dangerousness and intent of a particular attempt. The aforementioned (p. 24) far-reaching proposals of Schmidt and his associates, who assess future suicidal risk by the 'seriousness' of a particular attempt, appear of doubtful value in the light of the observations reported here. However, these studies confirmed the well-known observation that suicidal attempts in patients with depressive psychoses admitted to hospital are likely to be more dangerous and more serious than in other conditions.

The Suicidal Attempt in its Relation to the Social Field. Only rarely do suicidal attempts take place in isolation from the social environment. This seems to be true for attempts of all grades of dangerousness and intent, and even for suicides, though to a much lesser degree. To test these impressions, the suicidal attempt in its social setting has been investigated in the three groups where reconstruction was possible; in most instances the circumstances were still fresh in the memories of those concerned and additional information could be obtained. It was also possible to examine the social setting of the suicides and to compare them with the attempted suicides. The following aspects were investigated: site of the suicidal act with special consideration of its location in relation to the human environment; the nearness or presence of other people and their relationship to the person committing the suicidal act; whether or not he moved towards others in the course of the act; and the ways in which other people intervened. This enquiry confirmed the impression that most attempts appear to be made in such a way that an intervention of others seems possible or even probable. This applied to attempts of all grades of dangerousness and intent and to patients in all diagnostic divisions. It is justifiable, therefore, to view the suicidal act as a social behaviour pattern, i.e. a kind of behaviour which cannot be fully understood unless it is related to the human environment. This view accords well with certain psychopathological concepts concerning the suicidal act, which has been regarded as a manifestation of aggression against human objects with whom the individual has identified himself, or as an attempt at union with a dead person. As no relationship is free from ambivalence, and the desire to preserve life and human contacts is usually active side by side with the urge to

destroy, it is not surprising to find in the suicidal act itself manifestations of both tendencies, the social and the destructive, i.e. of love and hate. Which prevails, and thus decides the outcome of the act, depends not only on the degree of each of these tendencies present, but also on the response of the human environment, provided the latter is given a chance to intervene. The love and hate, therefore, which the person committing the suicidal act is subject to in his human environment, also play an important part in the outcome.

A comparison of the criteria indicating the social nature of suicidal attempts and of suicides showed that the social element, though not absent among the latter, was much less manifest than among the attempts. With some suicidal acts, the fatal outcome is due to lack of response from the environment. At least one of the subsequent suicides (p. 73) reported in this monograph belonged to this group; it illustrated the 'ordeal' character of the suicidal attempt which implies the possibility of a fatal outcome.

The observations presented have demonstrated that in the majority of suicidal acts the individual does not leave the social field or at least does not sufficiently move away from it in space and time to make himself independent of it. The tables demonstrating aspects of the social setting for the suicidal attempt show that only a minority were 'alone' during their suicidal acts; but this characterization of their spatial relationship to one of the many groups of which they are members tends to overstate the degree to which they had detached themselves from their human environment; it does not take into consideration the likelihood of their isolation being terminated at any time by an intervener, which actually happened to most who had been alone in the suicidal act. If all this is taken into account, survival appears at least as natural and legitimate an outcome as death, and it becomes clear that it is erroneous to divide suicidal acts in the successful and the unsuccessful attempts, death being the only criterion of success.

The social character of the suicidal attempt can be discerned irrespective of the underlying mental condition. There was no evidence that 'unsuccessful' suicidal attempts in psychoses were due to inefficiency or incapability in planning. In fact, the proportion of absolutely dangerous attempts undertaken with maximum intent was higher in the psychoses than in other conditions.

The recognition of the social character as inherent in the suicidal attempt, together with its destructive tendency, makes it impossible to regard a suicidal act as unsuccessful or abortive because it has not resulted in self-destruction. There is no one criterion of 'success' in behaviour so complex and based on contradicting motives. In this research the emphasis has been on the life-preserving tendencies inherent in the attempt with special emphasis on their social aspects.

This does not mean that the present writers do not regard the aggressive-destructive tendencies as extremely important, but as they have repeatedly been investigated clinically and psychopathologically, there is no need to discuss them here at length. The ways in which the conflict between life-preserving and life-destroying tendencies manifests itself in conscious and unconscious suicidal behaviour have been studied in detail by K. Menninger (1938)] who, however, did not consider the social aspects that are the subject of this research.

Another reason why the self-destructive tendencies cannot be regarded as the only motivating forces leading to suicidal attempts is that if they were, early and more determined repetition of attempts would be much more frequent. The fact that this is rare cannot be fully explained by lack of facilities in hospitals because patients persistently determined to kill themselves do so sooner or later even in hospital. Nor can it be explained by a change in the mental condition underlying the suicidal act. Admittedly a suicidal attempt, especially if it led to a state of unconsciousness, is sometimes followed by dramatic improvement in a depressive state, but this is much too rare to account for the infrequency of early and persistent repetition of suicidal acts of increasing violence. Nor can this be fully explained by the assumption that the discharge of self-destructive tendencies through the suicidal attempt brings about at least temporary equilibrium, not conducive to further attempts. Transient psychodynamic changes of this kind probably do occur, but cannot alone be responsible for the rarity of immediate repetition. Moreover, one would expect repetition to be most frequent where self-injury had been slight, which is not so. In the groups investigated in this research, tendency to repetition of suicidal attempts did not correlate with certain degrees of dangerousness and intent of the attempt under investigation. Although it was not possible to rate successive attempts when they constituted a regular behaviour pattern, there was no indication that as a rule they increased in severity.

Two further observations argue against the all-importance of self-destructive impulses in the motivation of suicidal attempts; the comparatively very small proportion of persons who, having made suicidal attempts, finally kill themselves, even among those who frequently react with suicidal attempts to stressful situations; and the corresponding fact that among the suicides only a minority have attempted suicide before. In the group of suicides examined here they constituted 14% only. In Sainsbury's (1955) much larger series it amounted to 17%.

The manifestations of the tendency to repetition of suicidal acts, or their absence, cannot therefore be fully explained by the peculiarities of the destructive impulses. Other tendencies underlying suicidal acts have also to be taken into consideration, especially the

social ones which will tend to neutralize the destructive impulses, at least for a time. Both have to be considered to understand the significance of suicidal attempts.

The Appeal Function of the Suicidal Attempt. With the suicidal attempt, one can observe the following sequence of events in most instances: a person who has not left his human environment, or has only loosely dissociated himself from it, has injured himself, or made himself sick or unconscious, frequently after having given some indication of his intention. He is found, resuscitated and helped by the community. This sequence of events is often repeated again and again. The uninformed observer of this pattern of behaviour would inescapably arrive at the conclusion that one of its functions must be an appeal to the human environment for help, irrespective of whether or not the person is aware of it. That some people, in attempting suicide, are aware, or almost aware, of this function of it and appear to use it purposefully, is well known. The majority of these people, whose suicidal attempts may be quite dangerous, show personality features and symptoms characteristic of hysterics and psychopaths. The present writers maintain that this appeal function is inherent in most, if not all, suicidal attempts although the person committing the act is as a rule unaware of this. This conclusion can be drawn both from the behaviour pattern and its effects on the environment. It is arguable whether one would be justified in regarding appeal for help as one of the unconscious *purposes* of this behaviour pattern because it regularly elicits helpful reactions from the environment. This is a question of definition. At any rate, every member of our society would expect some such reactions from the environment should he survive an act of self-injury.* He may expect other reactions also, particularly those which are responses to the aggressive component of suicidal behaviour.

If the appeal function is regarded as common to suicidal attempts there is no justification in dividing them into the genuine ones, i.e. those of whose appeal function the person is not aware, and the non-genuine, i.e. those in which he is aware. There is, in fact, no fundamental difference between them, although the impact on the environment tends to differ. Suicidal attempts whose appeal function is unknown to the person endangering his life seem to mobilize a greater desire to help than do the others, possibly by causing stronger feelings of guilt.

* The study of certain behaviour patterns in animals, which has been called 'ethology' (Lorenz, Tinbergen), has resulted in discoveries of importance to human psychology and psychopathology. Certain 'sign stimuli' emitted by one animal were found to elicit certain patterns of behaviour among other animals with great regularity. Where these stimuli gave rise to social behaviour patterns they were called 'Social releasers'. The suicidal attempt acts very much as a "social releaser". Whether the reactions it calls forth are innate or culturally determined remains to be explored

The realization of the appeal function of the suicidal attempt makes it understandable that it is not as a rule repeated immediately and with increasing violence. An attempt may have succeeded in this particular function by altering the person's circumstances temporarily or permanently, and may thus have removed part of the causes and motivations underlying the suicidal act.

The fact that the suicidal attempt has an appeal function does not by itself make it a hysterical reaction, as Strauss (1956) seems to believe. It only explains why suicidal attempts frequently occur in hysterics. Hysteria produces no behaviour patterns of its own: it avails itself, and accentuates common patterns, preferably those of high communicative value. If the suicidal attempt had no appeal function it would be less frequent among hysterics than among other personality types. The notion that 'the presence of a secondary gain—that is the advantages accruing from symptom formation in relation to the external world' (Strauss, 1956) is the chief criterion of a hysterical reaction, seems in need of qualification if one considers the social effects of attempted suicide. The same holds true for other symptoms, neurotic or otherwise. Most are apt to result in some secondary gain which, however, is usually out-weighed by disadvantages. The 'advantages' of being ill stem, of course, from the psychological effects that illness may have on the members of the group to which the afflicted person belongs.

The Ordeal Character of the Suicidal Attempt. Another feature of attempted suicide which is partly responsible for the fact that most people appear to be willing to accept the outcome of this act, i.e. survival, even as an invalid, without demur, was in an earlier communication (1952) designated as the 'ordeal character' of the suicidal attempt. The outcome of the majority of suicidal attempts investigated here was unpredictable because it depended on a number of factors outside, or not wholly under the control of the individual. This applied even to those relatively harmless. Because of the danger and unpredictability of the suicidal attempt, it has sometimes been likened to gambling, which might originate from similar motives. Psychopathologically, both seem to spring from the urge to test the balance between the libidinal and life-preserving tendencies on the one hand and the destructive impulses on the other hand. Many patients became aware of this feature of their suicidal acts if it was pointed out to them. Some realized it spontaneously, for instance the schizophrenic patient who, when asked the motive for his suicidal attempt, declared that it had been an act of faith: he wanted to prove whether God wanted him to live or die. He was aware of the ordeal character of his suicidal act, and he stated it with the clarity with which such patients often express common experiences and conflicts which to others usually remain unconscious.

The Social Effects of the Suicidal Attempt. The exclusive preoccupation of the students of attempted suicide with its self-destructive aspects has not only led to its being regarded as nothing but unsuccessful suicide, but has also been responsible for the total neglect of its social effects. This is indeed paradoxical considering that the importance of social factors has always been strongly emphasized in all discussions of the causations of suicidal acts. It almost seems as if the essential difference between suicide and attempted suicide had been overlooked, i.e. that the person who has attempted suicide lives on as a rule, and that the attempt becomes a significant event in his life and calls forth reactions from the human environment. The psychological and social sequelae of the suicidal attempt for the individual and his group had never been studied when this research started in 1951. A recent publication deals, however, with some aspects of this problem : Siegal and Friedman (1955) collected observations from psychiatric private practice, which illustrate the impact of the threat of suicide, including the repetition of a suicidal attempt, on members of the patients' groups and on society as a whole. ' Suicidal threats, other than psychotic reactions, pervade our entire social structure . . . the threat of suicide forces people to marry, prevents marriage dissolution, coerces companionship between persons despite their mutual infidelity, prevents marriages, forces parents to acquiesce in their offspring's vicious habits, precludes institutionalization, is rewarded by escape from military service, is used to obtain favoured treatment over siblings, is employed as a device to avoid military induction, etc.' It appears that the authors refer to the kind of warnings which so frequently precede suicidal attempts as well as suicides, and are too often disregarded, as well as to suicidal attempts which might be repeated. The way in which they present their observations suggests that their attitude to the appeal character of suicidal attempts is one of disapproval, and that they protest against their powerful effect on society. They exclude suicidal threats by psychotic patients from their censure, thus implying that they are not aimed at influencing the human environment. The authors, by their unsympathetic attitude to their neurotic patients' warnings, demonstrate that they share the popular belief that an honest, i.e. a genuine, suicidal threat or attempt has to be dominated by the purpose of self-destruction. They seem to regard any other effect, whether willed or not, as not germane to an act which is meant to kill, and which, if it failed, ought not be to used to alter a person's human relations and his life situation. The present authors have tried to demonstrate that in our society every suicidal warning or attempt has an appeal function whatever the mental state in which it is made. The question whether they are meant to be used as threats or only experienced as such by others through mobilizing their

feelings of guilt, is an unreal issue because the former would be impossible without the latter. That this powerful social appeal, like any other, can be purposely abused is self-evident.

In considering the effects of the suicidal attempt on the life situation of the patients in this research it must be kept in mind that all were hospital patients and that no conclusions can be drawn from these observations on the effects of suicidal attempts not followed by admission to hospital. Possibly, study of the sequelae of such attempts may reveal effects not observed in the hospital groups. At any rate the relative frequency of the various types of effect is bound to be different from those in this research. Among patients not admitted to hospital, the suicidal attempt may often remain without social effect.

A variety of social effects of the suicidal attempt has been found in patients where this problem could be studied. As none of the samples was representative, the frequency with which certain sequelae were observed, has, of course, no statistical significance.

It may appear strange that admission to hospital has been listed among the social effects of suicidal attempts. Hospital doctors often fail to realize the profound social significance of admission to hospital especially if it extends over months or even years. They are astonished when patients do not readily accept their offer of a ' vacancy ' and cannot understand why so many people should so strongly resist moving into an environment where hospital doctors feel so much at home. To the patient the decision to enter the strange world of a hospital is momentous, and the general practitioner, not working in hospital himself, is usually aware of this. Among hospital doctors other than psychiatrists, only pediatricians have recently become aware of the tremendous social change that removal to hospital implies. To adults, admission to hospital after a suicidal attempt must be among the most dramatic changes of social environment that a person can experience. It certainly is viewed as such by relatives and members of other groups to which the person belongs.

One of the striking findings of this research was the frequency with which the suicidal attempt was found to have been the only effective alarm signal to mobilize long overdue medical and social help. This applied both to physical as well as mental illness, but more so to the latter. A reason for this is the tendency to deny the morbid nature of mental change on the part of the patient and his group. This greatly adds to the difficulties in the recognition of mental illness which in most patients sets in gradually. Resistance to consult a psychiatrist is another factor responsible for the delay in hospital admission. On the other hand, sometimes the tolerance of mental symptoms appeared to be unlimited in the patient's group and it required the suicidal attempt to separate him from his family.

There were a number of patients among those recorded in this book, whose suicidal attempts were successful in securing them admission to hospital with subsequent recovery. An 'unsuccessful' suicidal attempt which had so obviously fulfilled a highly beneficial function is, conceptually, the counterpart of the proverbial 'successful' operation from which the patient died.

At this stage of the research no specificity can be claimed for the effects of suicidal attempts on the human environment. Such claims could be made only after these effects have been compared with those of other behaviour patterns; some, such as suicidal threats, mental and other illnesses, act on the environment as equivalents of suicidal attempts. Reference will be made to the social effects of illness below (p. 122).

Mourning and Reparation. In this study, little reference has been made to psychopathology. Its importance for the understanding of suicidal acts is fully recognized. No comprehensive presentation of attempted suicide is conceivable without consideration of its psychopathology and especially the contribution of psychoanalysis, but such a presentation is outside the scope of this monograph. The authors believe that in concentrating first on the social aspects of attempted suicide and firmly establishing its status as a behaviour pattern in need of special study, they opened new approaches for psychopathological research into suicidal acts, which has been at a standstill for some time. So strong has been the fascination with death as the only motivation in suicidal acts that even psychoanalysts who rejected the death instinct theory failed to consider attempted suicide as more than a suicide which has not come off. Schilder (1949), Massermann (1947) and Zilboorg (1936) regarded suicide as a manifestation of life-preserving tendencies aiming at immortality and permanent union with love objects, but they did not study these tendencies in and after the suicidal attempt. The detailed study of the psychological reactions of the members of the group to which the person attempting suicide belongs is a task for psychopathology. At this stage it is possible only to draw attention to the important rôle of mourning among the reactions of the environment. Although attempted suicide cannot be fully understood as an action aiming only at death, death nevertheless is in the foreground of the individual's thoughts before, during and after the attempt, and dominates the psychological reactions of his human environment. 'To the patient the suicidal attempt stands for death and survival, and often for a new beginning. To the relatives it stands for bereavement and mourning. It sometimes creates the peculiar situation in which somebody who has died and revived is with us alive while we are mourning him. All this engenders a tendency to renewal and revision of human relations on the part of all concerned' (Stengel, 1952). This characterization of

the psychological situation which was based on observations made in the follow-up of the first group presented here, has been found valid in many subsequent cases where the psychological reactions could be explored. Often the members of the individual's group behaved towards him after his suicidal attempt as they felt they ought to have behaved had he died. But whereas in the latter event they would have been at the mercy of their guilt feelings, the 'unsuccessful' suicidal attempt gave them the chance of allaying their guilt by redress and reparation. Many of the reactions of society to attempted suicide can be described in similar terms. Often these psychological reactions of mourning were transient and perfunctory, like mourning after bereavement, but they are probably never absent in our society which rates life and health above all other values and holds the mutual responsibility of individual and group for each other a basic moral tenet.

The Social Effects of Attempted Suicide Compared with those of Illness. Only those changes in a person's life situation were attributed to a suicidal attempt which could be directly related to it. Indirect effects, such as arose from results of treatment, were not included; for instance, with attempted suicide in depressive illness which subsided during hospital treatment, the resulting changes were not attributed to the suicidal attempt. Sometimes it was difficult to decide whether changes were due to the suicidal attempt or to the illness. In case of doubt they were not listed as effects of the suicidal attempt. Sometimes, when the illness was recurrent, it was evident that the reaction of the environment to a period of illness during which a suicidal attempt had occurred, was different from similar periods without suicidal attempts. This difference appeared one of degree rather than of quality. The social and psychological effects of illness, especially of mental illness, on members of the patient's group have never been studied systematically and it was therefore difficult to compare them with the effects of suicidal attempts. Nevertheless, at least with sudden illness, they have much in common with mourning reactions, although as a rule less obvious and dramatic than with suicide and attempted suicide. It would not be surprising to find a similarity between reactions to suicidal acts and to illness, especially to manifestations of mental illness, many of which have been regarded as psychologically related to suicide. (K. Menninger, 1939; H. Wilson, 1942; Stengel, 1943). This particular aspect of psychiatric symptoms has not been considered in this study. Several patients in the series had fugue states and other symptoms which have been regarded as suicidal equivalents (Stengel, 1943).

Apart from the psychopathological relationship between certain symptoms and suicidal acts, illness often means, like the suicidal attempt, a threat of losing a person. However, illness is not experi-

enced as a purposeful act of aggression directed against the self and the environment, and is therefore unlikely to call forth the same reactions as does the suicidal act, though perhaps part of them.

The Effects on the State of Isolation. Isolation has been regarded as one of the most important causes of suicide, and this has been confirmed by Sainsbury's ecological study. In the groups of attempted suicide presented here the proportion who lived under conditions of social isolation was almost as high as among Sainsbury's series, and in the group of suicides included here for comparison it was even higher. If psychological isolation due to mental illness or to difficulties in human relations, or the threat of it, was included, practically all cases could be viewed under this heading, and the changes resulting directly or indirectly from suicidal attempts could be described as changes in the state of isolation.

There was a great variety of changes in human relations arising from the suicidal attempts. One of the most interesting socially was a change towards greater dependence, which usually consisted in regression to an earlier state of dependence.

The Punitive Reaction of Society : Attempted Suicide as an Indictable Offence. The suicidal attempt is a complex behaviour pattern based on a variety of motivations : the wish to die, the desire to attack others, the appeal for help and the urge to challenge fate. To understand attempted suicide it is necessary to take all these motivations into account. The same holds true of the reactions of society to the suicidal attempt. Society, in our civilization, does as a rule everything to encourage the person who has tried to take his life to accept the outcome of the attempt, i.e. survival, without demur ; it responds to the appeal implicit in the attempt by coming to the individual's aid with all its resources ; it behaves as if it were not free from guilt of the barely averted death of one of its members. It does not, as a rule, react to the aggressive component by punitive measures. However, in England it has reserved itself the right to do so with the help of the law, according to which attempted suicide is a criminal offence. Thus, the variety of possible reactions of society to the suicidal attempt in England mirrors the components underlying it more completely and truthfully than in the rest of Europe.

The legal status of the suicidal attempt in Europe has undergone many changes. According to Weichbrodt (1937) and Schwarz (1946) it ceased to be a criminal offence on the European continent during the second half of the eighteenth century.

The belief is widespread that the threat of criminal proceedings has a preventive effect on suicide and attempted suicide. How much it is responsible for the comparatively low suicide rates in England it is impossible to say, in view of the many factors influencing the incidence of suicide. Schwarz looks at the English suicide rates with

suspicion; he assumes that the tendency to concealment must be higher in this country than elsewhere, owing to the legal status of suicidal acts. However, in Scotland, where legislation concerning attempted suicide is more in keeping with the continent, the suicide rates are even lower than in England and Wales.*

For the psychiatrist in England his patients' attitudes and reactions to the existing law are of considerable interest. The present authors have tried to study this question. However, it proved difficult to do so in the psychiatric interview, which was the main source of information available. The patient taken to an observation ward after a suicidal attempt tends to react with anxiety or even distrust if asked by the doctor whether he is aware of having committed an offence against the law, or what he thinks about the existing law, or whether he knows that there is such a law. This was why systematic questioning of patients on these points was soon abandoned as unrevealing and potentially harmful. Retrospective exploration during the follow-up yielded a variety of stereotyped answers, the truthfulness of which was frequently open to doubt. It was, therefore, impossible to find out how large a proportion of patients were ignorant of the legal status of attempted suicide. A considerable proportion maintained that they were. When given the information, some remembered having heard or read of cases which had come before a court of law, but on no occasion did a patient react as though guilty of having either consciously or inadvertently committed a legal offence. Many expressed the opinion that to take one's life was sinful and wrong, but did not think it the type of sin or wrongdoing which came into the orbit of the criminal law. This view seems to be shared by the Lord Chief Justice of England. In setting aside a sentence of two years' imprisonment for attempted suicide, he is reported to have stated that it was not a matter for the courts whether or not a suicidal attempt was a sin. He observed that a short sentence was often given to protect a man against himself (*The Times*, Law reports. 13th December 1955).

Admission to a psychiatric ward usually meant that no police proceedings were taken. The situation was different for patients admitted to a general hospital, where a person who had been brought into a medical ward unconscious would frequently find a police officer at his bedside waiting to take a statement. In such instances the patient's answers to the doctor's questions about his knowledge of, and his attitude towards, the law concerning attempted suicide are of doubtful value. It is not surprising, however, that such patients frequently maintained that their obvious suicidal attempts had been

* The suicide rates for England and Wales in 1951, 1952 and 1953 were 13·2 for males and 6·8 for females. The corresponding rates for Scotland were 7·7 and 3·4 respectively.

accidents. Patients admitted to observation wards sometimes also said this, but it has been the experience of the psychiatric investigator (E. S.) that suicidal intentions were denied more frequently when the patient was aware of the possibility or even the probability of criminal proceedings being taken than otherwise. Persistent denial of suicidal intentions frequently carried with it refusal of psychiatric treatment or rendered it more difficult, thus making a repetition of the suicidal act more likely. Here, the existing law proved potentially harmful for the patient. There was no indication that in the patients studied in the course of this investigation the law had a deterrent effect; it neither entered the patient's thoughts before the suicidal act, nor was it ever mentioned as a reason for not wanting to repeat the attempt.

A small number of patients among those examined had, on the occasion of previous suicidal attempts, been put on probation on condition that they would undergo psychiatric treatment, but for obvious reasons patients did not volunteer these statements, and their answers to questions on this point were unreliable.

The practice of the police authorities concerning attempted suicide varies from place to place and from time to time (Stengel, 1956). Some officers consider it their duty to take proceedings when they think that a person is likely to refuse treatment. In certain areas every second attempt is charged as a matter of routine unless the patient is given in-patient treatment. The existing law is applied capriciously and unpredictably.* The large majority of those brought before the magistrates' courts are bound over, but a small proportion of offenders are sent to prison, usually those previously bound over who had continued to make suicidal attempts. Often they have a police record for petty crime and may be alcoholics. They frequently are without friends and relatives. The present writers have seen no evidence that prison sentence for attempted suicide is a deterrent, though Norwood East (1911) thought so. He considered that the small number of persons who killed themselves, having served prison sentences for attempted suicide, indicated that the existing legislation was beneficial; however, he had failed to compare those cases with groups of people who had not received prison sentences for their suicidal attempts. The number of suicides among them is equally small.

The two patients belonging to Group I who served prison sentences for attempted suicide (pp. 63 and 64) illustrate both the kind of person likely to be made to feel the full force of the law, and the manner in which the law is applied. These cases demonstrate at

* In many instances the law seems to have undergone a peculiar twist; people are charged under it not because they intended to commit a felony but because they are thought to have pretended to have this intention.

what stage society, having failed to help these ' offenders ' by other means, resorts to punishment, however futile.

It is sometimes said in defence of the existing law that it is meant to penalize those who act from ' ulterior motives ' (N. East, 1911), i.e. who try to obtain by means of suicidal attempts what they are unable to obtain otherwise. It is the appeal function, therefore, of the suicidal attempt which is resented and punished in these cases, even if the danger to life is considerable. Punishment is supposed to act as a deterrent, but there is no evidence that it has this effect. The observations reported in this monograph, and the realization of the importance of the appeal function of the suicidal attempt, irrespective of the mental condition in which it is made, argue against a division of suicidal attempts into those with and without appeal purpose. Nor would it be possible to divide them into attempts with conscious and those with unconscious appeal function, the former being those with ' ulterior motives ' and therefore punishable. Awareness of the appeal function may exist side by side with strong self-destructive tendencies, even in psychotic subjects.

The law concerning attempted suicide is psychologically unsound and potentially harmful. Inevitably it tends to be applied in mental illness. Medical men have for a long time felt uneasy about this piece of legislation. In 1946 a special committee set up by the Council of the British Medical Association recommended the amendment of the law ' so that attempted suicide would not be dealt with as a legal offence '. It was pointed out in the Committee's memorandum* that nowadays legal machinery was hardly ever required to make a patient accept psychiatric treatment. For the exceptional case where this was so, it was suggested that a principle similar to that in the Children and Young Persons Act of 1933 might profitably be extended. Then adults in need of care and protection would be brought before the magistrates' courts to whom the necessary psychiatric advice would be available, so that consideration could be given to the best treatment for their rehabilitation. Since the special committee submitted their memorandum to the British Medical Association in 1947, there has been a considerable improvement in the psychiatric services ; more treatment facilities have become available and the readiness of patients to use them has increased. Is it too much to hope that the spectacle of sick people being imprisoned, or threatened with imprisonment, for their symptoms will before long be a thing of the past ?

Subsequent Suicides. The proportion of patients known to have killed themselves varied greatly among the three groups in which relevant information was available. It was smallest in Group I,

* The law relating to attempted suicide. *Brit. Med. J.*, 17th May 1947. Suppl., p. 103.

comparatively highest in the general hospital group. Altogether six patients were known to have killed themselves, and obviously, no generalizations can be made. Nevertheless, the results of all follow-ups so far available suggest that only a small minority of those who have made suicidal attempts are likely to kill themselves. This is in keeping with the observation that in only a minority of suicides is there a history of previous suicidal attempts. A high incidence of alcohol abuse seems to increase the risk of suicide among those who had made suicidal attempts before. This is in accordance with expectation.

With four of the six patients who killed themselves the circumstances leading to suicide could be explored. With none was it caused by persistence of the situation which led to the suicidal attempt under investigation. Even with the female patient who killed herself while still suffering from the depression in the course of which she had made a suicidal attempt, the motivations of the two suicidal acts were not entirely identical; they had been reinforced by a grave deterioration in her most important relationship. With the other patients the suicide occurred as the result of a recurrence or aggravation of the circumstances which had led to the suicidal attempts. There were strong indications that for at least two of the four patients the reaction of the environment was different from that to the previous suicidal act, thus making a fatal outcome more likely. These cases demonstrate that in assessing suicidal risk in attempted suicide the likelihood of such changes in the reaction of the environment has to be taken into consideration.

The Concept of Rôle applied to the Suicidal Attempt. Some sociologists have recently paid special attention to the various rôles which the individual plays *vis-à-vis* society. Suicidal attempt being a social act, the parts played by the participants can be described in terms of 'rôle theory' which promises to form a valuable link between psychodynamics and social psychology. Which rôles are inherent in the behaviour pattern of the suicidal attempt? On the part of the person performing the act there are at least two, i.e. that of the deceased to be mourned, and that of the aggressor. Suicidal attempt has been likened to a sham death, a behaviour pattern in which the animal's rôle is quite clear. This corresponds to the first of the two rôles mentioned although its purpose differs. The aggressive rôle is not always so obvious. The rôles of the members of the groups to which the person belongs are equally contradictory. Either they mourn, grieving and trying to do for the survivor everything they would have felt guilty of having failed to do had the other person died, or they hit back and sever their ties with him, thus symbolically killing the aggressor. In many instances the rôle played by the participants can be understood as combinations of, or compromises between, those rôles which may also alternate in the same person.

The language of rôle theory might prove useful in describing the psychological and social situations from which the suicidal attempts arise and the changes they produce.

Many suicidal attempts may be viewed as appeals for a change in the individual's human relations which have become intolerable. They might also be described as appeals for a change in an intolerable system of rôles existing within the person's group, or the absence of such a system. The effects of the suicidal attempt on the person's life situation, and on the modes of life within his group, might with advantage be expressed in terms of rôle theory which implies the focusing of attention on the social significance of behaviour without losing sight of intrapsychic events.

Communication Theory and Attempted Suicide. Another theoretical framework within which the social aspects of behaviour have been described and interpreted is that of communication theory which sees the individual in the context of a social situation. Ruesch and Bateson (1951) regard all psychopathological phenomena as disturbances of communication which are in part defined by the culture in which they occur. Communication includes transmission of all messages by which individuals influence each other. All actions, therefore, which can be perceived by others have communicative aspects. It is obvious that suicidal acts and their social effects lend themselves readily to description and analysis in terms of communication theory, both as messages and as responses from the environment. This approach is complementary to individual psychopathology which is concerned with intrapsychic events. It is sometimes erroneously assumed that the former has superseded the latter. Ruesch and Bateson (1951) have made it clear that ' what we need is a system which would embrace both events confined to the individual and events encompassing several people and large groups '.

Attempted Suicide in a Hostile Society. If the appeal function plays as important a part in the motivation and the effects of suicidal attempts as has been assumed here, one would expect suicidal attempts to be infrequent in a society which was either indifferent to this behaviour pattern or reacted only in a punitive manner. No society of this type exists in our civilization, not even a limited community within society. Even in prison, attempted suicide calls forth reactions, and has effects similar to those observed in the community at large. There existed, however, a kind of society which was openly hostile to its members, i.e. the German concentration camps. Several reports about the behaviour of the inmates have been published by medical observers who were themselves members of those communities (Tass, 1951 ; Kral, 1952 ; Cohen, 1954). They all agree about the extreme rarity of suicidal attempts in them, but about the occurrence of suicide they are less in agreement. Apart from ' occasional suicide epidemics ',

such as the one in which large numbers jumped from a height, the common type of suicide was very rare. However, Kral pointed out that to commit suicide the person had only to approach the wire to be shot or had only to relax in the struggle for survival to succumb rapidly. These deaths, which were not infrequent, would not be recognized as suicides. Cohen, on the other hand, explains the extreme rarity of suicidal acts by the nature of the community which was 'a realm of death'. He believes that the main function of suicide is escape; whereas 'in the realm of life' one could escape from life by committing suicide, one could escape from death only by living. The fact remains that attempted suicide was extremely rare in those communities. This appears to support the hypothesis of the appeal function of the suicidal attempt, provided one assumes that suicide of an atypical kind was frequent, which very probably was so. If, however, one refuses to accept this and assumes that, in those communities, all suicidal acts were extremely rare, one may attribute this to other factors, such as the lack of social isolation; and one may even speculate whether this remarkable phenomenon is not akin to the fall of the suicide rates during war when the value of individual life declines and society becomes less sympathetic, while social isolation is infrequent.

Suicides and Attempted Suicides: Two Populations or One? In this research, suicidal acts have been viewed as incidents in the course of struggle for adjustment. With attempted suicide this struggle continues, frequently under changed conditions. With suicide it has ended. This difference makes suicide and attempted suicide two different events for the individual and his environment. There is much to be said, therefore, for treating those who have attempted and those who have committed suicide as two populations. They are not sharply separated from each other because a minority of the one finally join the other. Psychiatrists and psychopathologists might hesitate to accept this division and might point out that the outcome of a suicidal act is an accident whereas its motivation is basically always the same. It has been shown that the outcome of a suicidal act depends on the relationship between its functions and the reactions of the environment. Lindemann (1952) is in favour of treating all who have committed suicidal acts as one population suffering from a common illness which he proposes to study in terms of morbidity as well as mortality. This interesting proposal has certain disadvantages: it introduces an artificial illness of doubtful status; as its main symptom is a common mental attitude not necessarily associated with suicidal acts, the delimitation of this 'illness' is bound to be uncertain. K. Menninger has shown that the consistent application of psychopathological criteria alone militates against the singling out of those who commit suicidal acts in the accepted sense from the

many others whose self-injuring tendencies manifest themselves differently. The advantages of assuming two populations have been amply demonstrated by this study. However, if we want to treat all who commit suicidal acts as one population, we must realize that it is a population of people who have made suicidal attempts, with a minority who have killed themselves. To make the fate of that minority the condition of full membership of that population, and to treat the majority as inferior members, is impermissible. But this is exactly what most workers have done.

The Implications of this Research for Prevention of Suicidal Acts. Sociologists and psychiatrists alike have, when discussing prevention of suicidal acts, always advocated measures against isolation as well as treatment of an underlying mental illness. The investigations presented here confirm the soundness of this advice, but they also teach certain lessons the observation of which may be of practical importance. The recognition of the appeal function of the suicidal attempt implies that warnings of suicide have to be taken seriously; the individual's life situation has to be explored with a view to helping him towards a new adjustment. The same applies to the situation after a suicidal attempt, which carries a message to the human environment. This message, of whose meaning the person is frequently unaware, has to be deciphered and formulated. An understanding of the individual significance of the appeal inherent in the suicidal attempt would enable those who want to help to do so rationally and effectively and thus prevent repetition. The exploration envisaged here would not necessarily require much time and would usually be possible with the help of the psychiatric interview. An understanding of the social significance of each suicidal attempt appears desirable also in the psychoses. We do not believe that treatment of the underlying mental disorder alone is enough. Possibly, such studies may contribute towards an understanding of the still unsolved problem of why proneness to suicidal acts varies even among patients suffering from depressive illness.

The study of the suicidal attempt as a social act has thrown light on the part played by the human environment in all its stages and in its prevention. It follows from these observations that a great deal of attention has to be paid to the patient's group because they are potential participants.

The present writers hope in due course to elaborate on these suggestions and to illustrate their application on clinical material.

The limitations of the psychiatrist's contribution to the reduction of the suicidal rates have been referred to earlier, on p. 14. Nevertheless, prevention or even drastic reduction of suicide among those who have attempted suicide before would be a considerable achievement. Although they form only a small proportion of that large

group, their number is high compared with the incidence of suicide among the general population. But apart from the danger of suicide, it is important to reduce the incidence of attempted suicide, one of the most disturbing and costly abnormal behaviour patterns in our society. In addition to carrying out the task of preventing suicidal attempts among his clientele, the psychiatrist has a part to play in the shaping of prophylactic measures, but their discussion is not within the scope of this monograph.

Chapter 16

CONCLUSIONS

The present state of research into suicide and attempted suicide has been surveyed. It has been shown that so far research into attempted suicide has followed the same lines as suicide research.

Reasons for studying attempted suicide as a behaviour pattern of its own have been advanced.

The problem of the incidence of suicidal attempts has been discussed and it has been pointed out that representative samples of persons making suicidal attempts cannot be obtained.

Five groups of patients admitted to hospital after a suicidal attempt and a series of suicides have been investigated.

In two groups follow-up investigations have been carried out and it has been found that within the period surveyed only a very small number of patients had killed themselves.

The composition of the groups has been examined and compared with the series of suicides. The representation of the social classes has been found to be different.

The significance of the broken home for proneness to suicidal acts has been discussed.

Social isolation has been found to play the same part in the causation of attempted suicide as in that of suicide.

Suicidal acts have been viewed as social behaviour patterns and the participation of the human environment in them has been investigated. An appeal to the human environment has been shown to be one of the primary functions of the suicidal attempt irrespective of its psychiatric background.

Suicidal attempts have been rated for dangerousness of method and seriousness of intent. These factors have been related to each other and to the mental conditions present at the time.

The immediate and remote social effects of the suicidal attempt have been investigated. A variety of effects have been established. Some have been found to be closely related to the psychological processes of mourning.

The manifestation and the significance of the punitive reaction of society to attempted suicide have been examined.

The relationship between the social effects of attempted suicide and those of illness has been discussed.

The circumstances leading to subsequent suicide have been investi-

CONCLUSIONS

The extreme rarity of attempted suicide in a community hostile to its members has been interpreted as confirmation of the importance of its appeal function.

The application of the rôle theory and of the communication theory to suicidal acts has been discussed.

The need to treat those who attempt suicide and those who commit suicide as two different though overlapping populations has been pointed out.

The implications of the results of this research for the prevention of suicidal acts have been discussed.

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